MEDICAID FRAUD—PRESCRIPTION DRUG DIVERSION

HEARING

BEFORE THE

HUMAN RESOURCES AND INTERGOVERNMENTAL RELATIONS SUBCOMMITTEE

OF THE

COMMITTEE ON GOVERNMENT OPERATIONS HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRD CONGRESS

FIRST SESSION

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MEDICAID FRAUD—PRESCRIPTION DRUG DIVERSION

MONDAY, AUGUST 2, 1993

HOUSE OF REPRESENTATIVES,
HUMAN RESOURCES AND
INTERGOVERNMENTAL RELATIONS SUBCOMMITTEE
OF THE COMMITTEE ON GOVERNMENT OPERATIONS,
New York, NY.

The subcommittee met, pursuant to notice, at 9:30 a.m., in the Public Hearing Room, City Hall, New York, NY, Hon. Edolphus Towns (chairman of the subcommittee) presiding.

Present: Representatives Edolphus Towns, Steven Schiff, and John L. Mica.

Also present: Ronald A. Stroman, staff director; Allegra A. Pacheco, professional staff member; Martine M. DiCroce, clerk; and Martha B. Morgan, minority professional staff, Committee on Government Operations.

OPENING STATEMENT OF CHAIRMAN TOWNS

Mr. TOWNS. The Subcommittee on Human Resources and Intergovernmental Relations will come to order.

Today, the Human Resources and Intergovernmental Relations Subcommittee will examine Medicaid fraud. During the past decade, an unprecedented crime wave of multimillion dollar fraud has emerged within the Medicaid program. This fraud includes organized networks of colluding doctors, pharmacists, and middlemen. These so-called "Pill Mills" have victimized New York City, and other major urban areas.

In one variation of this scam, physicians operate out of store front offices, for the exclusive purpose of exploiting the Medicaid program. Physicians write unnecessary prescriptions and bill Medicaid for unnecessary tests. The pharmacist bills Medicaid for the filled prescription. The patient then sells the unneeded drugs to a middleman, who will resell the prescription back to the pharmacy.

Prescription drug fraud is widespread, costing New York City up to $100 million a year. GAO has concluded that many Medicaid agencies maintain inaccurate data, have no early warning system for fraudulent billing patterns and are badly understaffed. There is often poor coordination between State and Federal enforcement efforts, and minimal oversight by the Department of Health and Human Services. Incredibly, many providers who have committed Medicaid fraud are still participating in the program.

Unlike some white collar crime, Medicaid fraud is not victimless. When inappropriate drugs are prescribed or appropriate medication

is diverted, the health and safety of Medicaid patients is placed at risk.

Health care fraud is a major factor in the spiraling cost of health care. All of us pay for this fraud, as insurers pass these losses along to consumers, by increasing health insurance premiums. The GAO estimates that up to $90 billion—that's "B" as in "boy"—a year in fraud is wasted due to fraudulent and abusive providers. This fraud also helps keep 37 million Americans without any health insurance at all.

The simple truth is that Medicaid fraud is being committed by highly sophisticated medical providers. The chances of being caught are slim. If caught, the chances of receiving any serious sanctions are even more remote, so that Medicaid fraud pays. We must change this equation.

We need to develop more accurate Medicare data systems. Federal, State, and local agencies must find better ways of sharing information on fraud. We need more coordinated Federal and State fraud investigations, to make more efficient use of limited enforcement resources. We also need better oversight by the Health Care Financing Administration. Finally, we must insist that people convicted of this fraud be punished to the fullest extent of the law, including exclusion from participation in the Medicaid program, license revocation, and where appropriate, prison.

I believe we must strongly resist efforts to cut the greatly understaffed Medicaid investigative unit. Without a comprehensive attack on these criminal enterprises, health care in this country will remain in critical condition.

I would like to yield, at this time, to the ranking minority member of the subcommittee, Mr. Schiff of Albuquerque, NM.

Congressman Schiff.

Mr. SCHIFF. Thank you, Mr. Chairman.

Just a couple of very brief things. One is, of course, welcome to our colleague, Congressman Rangel, about to testify. Second, I appreciate being invited to New York State and New York City. I've been here a few times, always a wonderful experience. I appreciate your hospitality. Finally, I want to congratulate you most sincerely on holding this hearing.

I, when I was district attorney for a period of time, the State's Medicaid providers fraud unit operated out of my office, although now it's more appropriate to locate it with the State attorney general.

And, as I look at government health care programs, I came to the conclusion—two conclusions.

No. 1, we may agree or disagree about what type of system we want, but nobody wants fraud. Fraud bilks the system. I don't care what kind of system you have. And, it takes away from the taxpayer and it takes away from the recipients.

Second, I've come to the conclusion that when one talks specifically about a welfare program, like Medicaid, and fraud, the picture is the recipient committing fraud, and some recipients do commit fraud. I don't think any of us can deny that. But, I'm convinced that the great damage in a system like this is committed by the providers, by people who ought to be and pretend to be professional members of the society.

The plain fact is, how much fraud can any recipient claim? How many children can you say you have, before someone starts getting suspicious. But, providers can commit almost an unlimited number of frauds, provided that the total amount of billing that they do doesn't so far exceed norms to the profession as to create some suspicion there. Or, to put it the other way around, an individual can only receive so many, so much of a prescription drug, but a pharmacist or a physician can prescribe, in a sense, almost limitless numbers of that same prescription. And, if fraud is involved, it is the provider who will cost the system a great deal more money.

So, I appreciate your holding this hearing on this important subject, and I yield back.

Mr. TOWNS. Thank you, very much, Congressman Schiff.

I now yield to Congressman Mica, for any opening statement he might have.

Mr. MICA. Thank you, Mr. Chairman, and I, too, want to echo the sentiments of the ranking member here today, and commend you on holding this hearing.

You have really been one of the outstanding subcommittee chairmen in the Congress, and your record of holding these hearings and focusing on matters of attention such as this are a real credit to the Congress.

And I'm glad to see Mr. Rangel, my colleague, here, too, the voice many of the unheard in the Congress, and delighted to see him before our subcommittee, too.

I read some of the background, and I see the GAO report, and the information contained in there, quite frankly, is shocking, when you see that you could really fund the entire health care needs of the Nation just through the fraud, waste, and abuse which, in the private sector and the public sector, in what we're going to hear today, amounts to some $90 billion. And, it's prevalent not just in New York and the States that were examined here, but also Florida, California, and Texas, and you see the dramatic increases of prescription drug costs from $5.5 billion to $10 billion since 1991.

So, again, I'm pleased to see that you're paying attention to this most important issue and only sad that there's not more attention to this.

Thank you, again, for holding this hearing.

Mr. TOWNS. Thank you, very much, Congressman Mica, for your kind words and also to say that he's been a very active member of this subcommittee, as well, and we really appreciate that.

At this time, I would like to call on our first witness, the Honorable Charles Rangel, a highly respected Member of the U.S. Congress, on both sides of the aisle. He's also dean of the New York State delegation.

He's a distinguished member of the powerful House Ways and Means Committee, and currently head of the House Emergency Room Caucus.

Mr. Rangel is also the former chairman of the House Select Committee on Narcotics Abuse and Control, and the original requestor of the work that the General Accounting Office will be presenting later this morning, on prescription drug diversion in the Medicaid program, and we would like to thank him for that.

Mr. Rangel, we would like to welcome you to the subcommittee, and you know the rules in terms of how we proceed, and you can do that and move forward in any way you feel that you would like to do at this time.

But here, again, we would like to thank you for coming and also to thank you for the work that you've done up to this point, to get us where we are today, and your encouragement in this regard has meant a lot to all of us, so you may proceed.

STATEMENT OF HON. CHARLES B. RANGEL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Mr. RANGEL. Thank you, Mr. Chairman. I'd like to have consent to put my written statement in the record.

Mr. TOWNS. Without objection.

Mr. RANGEL. Mr. Chairman, after that gracious introduction, I could only wish that my wife was here today to hear that, but I want to thank the committee. I want to thank Mr. Mica and, of course, my costudent in Washington, Mr. Schiff, but especially you, because as Mr. Mica said, this is a great committee with a great tradition. And, as he was speaking, I was thinking of Ben Rosenthal, who left us, and Ted Weiss, who left us, and you should feel proud that you will be able to not only carry on that tradition, but to leave your own legacy for those of us in the Congress to be proud of.

Not too many things get me excited in terms of committee work, unfortunately, but this, certainly, is one of them. And, when I heard that you were going to have these hearings, I just wanted to rearrange my schedule to make certain that I would give all of the support that I could to your leadership in this committee, because really you have a tiger by the tail, that may be difficult to hold onto. But, the whole Nation would be grateful to you if, with the help of your colleagues and other committees, we could work out something so that we don't let this one fall between the cracks.

We're going to have to have new laws. We're going to have to work with local district attorneys and State attorneys general and also with the fraud units, the special prosecutor of the Medicaid fraud units. We're going to, as you pointed out—your opening statement almost said it all—we're not only going to have to change the laws, but we're going to have to enforce the laws, and you can't do that by cutting back the funding or changing the ratio for those people who are saving us money by successfully prosecuting. And, I think that it's often said that the arrest and convictions are deterrents, not just sanctions and punishment. But, in this particular case, it is so true, because the slime that comes from under the rocks and call themselves doctors and pharmacists only see the opportunity to make millions of dollars and go into these fraudulent businesses almost without fear of losing their license, without fear of going to jail. And, you close one up and they pop up some other place.

Because you have such experts that are working with this from day to day, I intend to be brief, subject myself to questioning, but more important, to commit myself to your work.

A little over 10 years ago, in the Harlem and east Harlem community where I was born and raised, I would see large numbers

of mainly young people lining up outside of stores that had new signs on them, saying "Medicaid, doctor available." There were different times that the stores would be open, and unlike the Medicaid mills that took advantage of all of the poor folks, whether you were young or old, it was abundantly clear that these store fronts were operating something just for drug addicts.

I started walking into these little store front stores, and it would seem like they just had one contractor throughout the Harlem community, because as soon as you walk in, you see this big wall of plasterboard, with two windows in it, with one door on the side.

That one door—and anyone could walk in and intimidate them. When you're violating the law, and most all of them were newcomers to this country, and some of them knew who I was, but I never was with any big group. It was mainly by myself. I would just walk in.

You could smell the stench of vomit and urine and you walked into the medical section of these mills. And all of them were basically the same. You may remember those places they used to have in Coney Island, where you had these little, little rooms just to change into your bathing suits, and that's all they were, or something that the men might see or the women might see, to try on clothes in some of the stores. But the smell and the stench would make you want to throw up.

There were so-called doctors there, but it was clear to me that if they were not, if they had not lost their medical license, that many of them, really, were in such bad shape with drinking, unshaven, looking filthy, that you would know that these doctors were there for one purpose and one purpose only—to sign prescriptions.

Everyone had to come in with their Medicaid card, or they would get it for you. And they had to disrobe, because the police tell me that they want to make certain that they weren't dealing with a police officer or someone that was wired. They also sometimes would take a blood test for the first time you're in, knowing the reluctancy of police officers or undercover agents to be willing to have any type of blood needle being used in one of these places.

Well, once they were convinced that they were dealing with an addict, then this person really had an American Express card to steal millions of dollars from the American taxpayers, because once they determined what illness the doctor said they had, then they no longer needed any further examinations. They would just come in for their prescriptions.

And, what do they do with the prescription? In the same store front, in every place that you would see, there was a hole in the wall where the doctor's side would give it to some newcomer to the country, again, to the pharmacist's side. Many of the prescription drugs were already packaged. There were no names on them. They just knew how many pills they were pushing that day.

I cannot talk too much about the leadership of Edward Kuriansky. I know that Thomas Staffa, of the criminal division of the New York State special prosecutor's office for Medicaid, but on several occasions they provided the leadership in raiding some of these places, with the help of the attorney general and, certainly, the local district attorney's office, headed by Bob Morgenthau.

But, in each time that we went in, we saw the same filthy conditions and, most of the times, these doctors would bounce right back up. They just look for places and every time we had someone, they were owned by a foreigner. These doctors were brought in from God only knows where, and the pharmacists were just saying that they were just following out what was written on the prescriptions. In some of these cases that have been successfully prosecuted, and God knows how many are out there, we would see warehouses of these pills that people had in their homes, having it ready to ship it overseas, to the Dominican Republic or to Mexico.

At other times, some of our TV cameras have captured the so-called "patient" selling the wares right outside of the Medicaid office. And, of course, in addition to pills, anything else that they could take and sell—whether they were heating pads, canes, or whatever that these people had available that they could charge the Medicaid—is being done.

We've had a lot of successful cases with Bob Abrams and all of law enforcement. But, we've never really had a national effort, in my opinion, that we would teach these people a lesson. Bring in the American Medical Association and the American Pharmaceutical Association, the Secretary of Health and Human Services, the Director of HCFA, and also, as we have today, representatives from Texas and other States, to start a national movement where, once and for all, we would say that in a Nation as rich as ours that seems like it can't afford to provide full coverage for the poorest of our poor, at least we could save the billions of dollars that are wasted by rooting out these people that are really unworthy of being in this country, unworthy of being associated with doctors and pharmacists, and unworthy for community leaders to allow them to open up these type of places in their community.

We have so many problems that it's difficult for one person or one agency to really concentrate on any one aspect of the drug problem that our Nation and, indeed, the world faces today. But, I promise you, that if we can say to each other that we're not going to let this one go, I will work day and night in trying to work with this committee in bringing together the local and State prosecutors that, with your help on the Select Narcotic Committee we still keep in communication with, and we will reach out to make certain that the Clinton administration, working with the Congress, in a bipartisan manner, might see fit to put this, too, on its priority, as it relates to narcotics and health provision.

So, I close in saying that all of you, from your opening statements, are fully aware of how important this problem is to solve and I just want to let you know that I'm anxious to work with you toward that solution, and I appreciate, deeply, the honor that you give me to kick off the testimony for this morning's hearing.

Thank you.

[The prepared statement of Mr. Rangel follows:]

TESTIMONY OF

CONGRESSMAN CHARLES B. RANGEL

BEFORE

U.S. HOUSE OF REPRESENTATIVES
COMMITTE ON GOVERNMENT OPERATIONS
SUBCOMMITTEE ON HUMAN RESOURCES AND
INTERGOVERNMENTAL RELATIONS

PUBLIC HEARING ROOM CHAMBER
CITY HALL
SECOND FLOOR
NEW YORK, NEW YORK

AUGUST, 2,1993

GOOD MORNING CHAIRMAN TOWNS AND MEMBERS OF THE SUBCOMMITTEE ON HUMAN RESOURCES AND INTERGOVERNMENTAL RELATIONS. I APPRECIATE THE CHAIRMAN AND THE SUBCOMMITTEE JOINING WITH ME IN THIS CONTINUING INVESTIGATION INTO MEDICAID FRAUD AND SUBSTANCE ABUSE.

A NUMBER OF YEARS AGO, AS CHAIRMAN OF THE SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL, I BEGAN AN INQUIRY INTO THE PERNICIOUS BUSINESS OF "PILL MILLS", WHICH SEEMED TO FLOURISH IN MANY POORER COMMUNITIES THROUGHOUT THE NATION. FOR YEARS I HAVE BEEN AMAZED BY OPEN AND APPARENTLY UNIMPEDED SALE OF ILLICIT DIVERTED PRESCRIPTIONS AND PRESCRIPTION DRUGS ON THE STREETS. I WAS ASTOUNDED TO LEARN THAT THESE PRESCRIPTIONS AND DRUGS FIND THEIR WAY INTO THE DRUG TRAFFIC THROUGH THE COLLUSION OF LICENSED DOCTORS AND PHARMACISTS. IT IS ALSO A FACT THAT DOCTORS, PHARMACISTS, AND THE MEDICAID PATIENTS THEY TREAT ARE REIMBURSED FOR THEIR EFFORTS BY EITHER PROFESSIONAL DRUG DEALERS OR THE TAXPAYER IN THE FORM OF MEDICAID REIMBURSEMENT.

HOWEVER, BECAUSE MANY OF THESE SCHEMES SO CLOSELY PARALLEL IN APPEARANCE THE LEGITIMATE DOCTOR-PHARMACIST-PATIENT RELATIONSHIP, THEY ARE DIFFICULT TO INVESTIGATE AND PROSECUTE. THESE TRANSACTIONS HAVE BECOME A MAJOR, MULTI-STATE, MULTI-MILLION DOLLAR ENTERPRISE, WHICH CORRUPTS THE ESSENTIAL FABRIC OF THE INNER CITY, FUELS THE SPREAD OF ILLEGAL DRUG USE AND RELATED CRIME AND VIOLENCE, AND BANKRUPTS A FEDERAL PROGRAM ON WHICH MILLIONS OF POOR AMERICANS RELY FOR THEIR HEALTH CARE.

LAST MONTH. MR. CHAIRMAN, THE FORMER U.S. SECRETARY OF HEALTH,

EDUCATION AND WELFARE, JOSEPH CALIFANO, WHO IS NOW SERVING AS PRESIDENT OF THE CENTER ON ADDICITON AND SUBSTANCE ABUSE (CASA) AT COLUMBIA UNIVERSITY, RELEASED A REPORT THAT ESTABLISHED THAT ONE OF EVERY FIVE MEDICAID DOLLARS - OR 20 % - SPENT ON IN-PATIENT CARE IS RELATED TO SUBSTANCE ABUSE. I HAVE TOLD SECRETARY CALIFANO IF YOU ADD IN THE THE VARIOUS DRUG ABUSE-RELATED FRAUDS THAT PLAGUE THE MEDICAID SYSTEM - AS WE ARE DISCUSSING HERE TODAY, I WOULD HAVE EVERY CONFIDENCE IN ASSERTING THAT ONE OUT OF EVERY FOUR MEDICAID DOLLARS - OR 25% - IS SUBSTANCE ABUSE RELATED. THIS IS A FISCAL HEMMORRAGE THAT OUR NATION CANNOT AFFORD, AND ONE THAT WILL CERTAINLY UNDERMINE THE ADMINISTRATION'S EFFORTS AT HEALTH CARE REFORM IF NOT ADEQUATELY ADDRESSED IN THE PRESIDENT'S FORTHCOMING PLAN.

WE HAVE WITH US TODAY, REPRESENTATIVE OF THE GENERAL ACCOUNTING OFFICE (GAO) WHO I ASKED SOME TIME BACK TO INVESTIGATE THIS FRAUDULENT CONDUCT AND REPORT BACK WHAT RECOMMENDATIONS THEY WOULD MAKE TO THE CONGRESS FOR CORRECTIVE ACTION. AT A HEARING OF THE SELECT COMMITTEE LAST SUMMER, GAO PRESENTED SOME PRELIMINARY FINDINGS THAT OUTLINED THE NATURE AND SCOPE OF THE PRESECRIPTION DRUG/MEDICAID FRAUD PROBLEM, AND WHAT ACTIONS VARIOUS STATE AGENCIES WERE TAKING TO ADDRESS IT.

I AM PLEASED TO NOTE THAT TODAY THE GAO WILL BE PRESENTING ITS FINAL REPORT TO US. GAO HAS MADE THE FOLLOWING KEY FINDINGS:

- PRESCRIPTION DRUG DIVERSION IS A PROBLEM IN MANY STATES, OFTEN OCCURRING IN CONJUNCTION WITH OTHER TYPES OF FRAUD.

- THESE FRAUDS ARE OF MANY VARIETY, INCLUDING AN ORGANIZED

NETWORK OF COLLUDING PHYSICIANS, PHARMACISTS, PATIENT BROKERS, AND MIDDLEMEN THGAT ILLEGALLY TRANSFERED MONY OVERSEAS THROUGH THE BANK OF CREDIT AND COMMERCE INTERNATIONAL (BCCI).

- IN THE PAST, NO ONE AT THE FEDERAL OR STATE LEVEL APPEARED EAGER TO ASSUME FRONTLINE RESPONSIBILITY FOR A FULL-SCALE ASSAULT ON THIS PROBLEM. INADEQUATE INVESTIGATIVE REOURCES HAVE BEEN TARGETED AT THE PROBLEM.

- THERE IS A NEED FOR MEDICAID CONTROL AGENCIES TO SUPPLEMENT PREVENTION EFFORTS, WITH ADDED SUPPORT FOR INVESTIGATION, PROSECUTION, ENFORCEMENT, AND RECOVERY EFFORTS. IMPORTANT TO THE SUCCESS OF THESE EFFORTS IS THE NEED FOR CLOSER COORDINATION AND COOPERATION BY ALL RELEVANT AGENICES INVOLVED IN POLICING MEDICAID, PHYSICIANS, PHARMACISTS, AND CONTROLLED SUBSTANCES.

MOST IMPORTANTLY, MR. CHAIRMAN, GAO FINDS THAT THE HEALTH CARE FINANCING ADMINISTRATION (HCFA) MUST ASSUME AN ACTIVE LEADERSHIP ROLE IN ORCHESTRATING STATES' EFFORTS BY CONDUCTING CONCERTED ASSESSMENT AND GUIDENCE ACTIVITIES. GAO RECOMMENDS THAT SECRETARY SHALALA AND HCFA ADMINISTRATOR VALDECK DEVELOP AN OVERALL STRATEGY TO ADDRESS PRESCRIPTION DRUG DIVERSION AS PART OF THE LARGER PROBLEM OF MEDICAID FRAUD.

I LOOK FORWARD TO THE TESTIMONY OF THE WITNESSES, AND TO WORKING WITH THIS SUBCOMMITTEE ON THE IMPLEMENTATION OF THE GAO RECOMMENDATIONS.

Mr. TOWNS. Thank you, very much, Congressman Rangel, and we really appreciate your testimony. We know that you've been very involved, in terms of leading, providing leadership to the Select Committee on Narcotics, and also in reference to this subcommittee, as well.

Let me ask you, do you feel that we're getting a real handle on the pill mills, or would you say that there are more now than 5 years ago? Are we doing better or worse or just holding our own?

Mr. RANGEL. I think we're doing just a little less than holding our own. Because they are being closed, we are using computers, we are checking out more. But, every time someone would tell you that we're getting a handle on the drug addiction problem, you always hear them mumble something like, "but not in the hard-core areas, that is still a major problem."

So, wherever they're having these successes, it's not in my community and communities like it, so we find a continuous explosion of drug addiction, including now a sharp increase in the rise of pure heroin being used, and these pills used for ups and downs and everything in the world. And, somehow, the doctors still have no fear in coming back, reopening the same stores, new stores. They pay high rent, and so we have not got a handle on this problem at all, Mr. Chairman.

And, really, you don't have to have hearings. If one day we decide, if we're in recess, just to drive around the several communities we have, take my word for it, if I show you a brandnew, fancy sign—"We take Medicaid"—and you take a look and see young people, and sometimes older addicts, standing in a long line, then you would know that's the place.

Mr. TOWNS. Let me ask you, because we know of your experience and want to take advantage of this opportunity, do you have any specific recommendations for this committee? Things that we might be able to do now to begin to get people to focus on this problem?

Because, as was pointed out here by Congressman Mica, we are wasting enough to insure the 37 million people that are uninsured. We're talking about $90 billion that we're probably wasting in terms of Medicaid fraud, and the 37 million that are uninsured, that would probably be enough to bring them into the system. So, we see it as a very serious problem.

So, what are the recommendations that you would like to give, at this time?

Mr. RANGEL. First of all, we're at an all-time high in drug enforcement agents, and even that, we have less than 3,000 in the United States of America and in 44 countries. And so, you have to be in pretty bad luck to be busted by a DEA agent.

Local officials and State officials are the major fighters in this area of fighting drug trafficking. And, certainly, it has to be true. That is, the local and especially the State prosecutor's office that deal with Medicaid fraud, that provide the leadership in this area.

The first major thing we should do is take a look at the funding, because while now they get 50 percent matching funds, there is a move—not in the Congress, but certainly in the past administration, and perhaps, in this one, since you know the fight that we have with Medicaid and Medicare—to change that formula to 75 percent local and State and 25 percent Federal. That doesn't make

sense. This is one of the few agencies that really save the government money, far more than we're asking for them to share in the responsibility for prosecuting.

We have to change some of the laws, to make it a felony so that the so-called "addict" will know, and the providers would know, that giving out drugs and kicking those drugs back in means long time.

We have to really embarrass the AMA and the American Pharmaceutical Association, as I have tried for over 10 years. They have to assume some responsibility for the people of their profession that are caught red handed, committing crime, and are still able to hold those darn licenses.

And they're a powerful force in this country, believe me. And we're going to have to get them to cooperate. God knows, the first thing a lawyer wants to do, if he hears another lawyer's guilty of anything, is to take the case free in order to disbar him. But, the doctors somehow don't have the reputation of assisting in cutting out this fraud and corruption that exists.

And, I would think that the leadership has to come from Washington. Of course, we need the resources in order to pump up and to make certain that the investigators and the prosecutors are able to be successful, because they're dedicated. They don't get paid much. They do it because they have a feel for public service and are willing to cut this scum from our communities. But, the leadership has to come from Washington and, Chairman Towns, I am convinced that this subcommittee, together with other Members in the Congress, can make this just as much a priority as it is to balance the budget, to raise the taxes, and to cut spending.

You've said it 101 million times—if we're going to have full coverage, we just can't afford to do it until we get out the corruption that's within the system today.

Mr. TOWNS. Thank you, very much, Mr. Chairman. Thank you for your testimony. I'd like to yield at this time to Congressman Schiff, the ranking member.

Mr. SCHIFF. Well, as usual, it's difficult to get the last word with Congressman Rangel, just because you've said everything so eloquently that needed to be said here, truly.

I have just one question: As you know, on behalf of the administration, Mrs. Clinton is heading up the health care task force. I wonder if you happen to know whether further addressing fraud within health care providers is made a prominent part of the plan as it is now shaping up in the White House? I know it is not a final plan, in any way, so nothing I would ask is binding, but I wonder if you know if they've taken a serious look at that.

Mr. RANGEL. I don't know, Mr. Schiff.

I can say, I can't think of any member that's been asked more questions by this administration, on more subjects, than I. But they've really never shared with me, even after they completed their work, exactly the direction that they're going.

But, I can tell you this: That with your support, it really doesn't make any difference. It would help, if they're knowledgeable and sensitive and they know about the problem. I can assure you of that.

But we can turn it around, because at some point, we're going to have to start working together for common objectives and common goals, because drug addiction and this misery doesn't know any party label and I know we can depend on you and others and the leadership in the House and Senate. We can win this one.

Mr. SCHIFF. Thank you, very much, Congressman Rangel.

If the subject comes up, I'm sure we can put together, very easily, a bipartisan group on this subject, to visit the administration on it.

Thank you, Mr. Chairman. I yield back.

Mr. RANGEL. I'm going to take this back to the Narcotic Caucus, so that you will know the names of the people that you don't even have to lobby, so that would be your support team, and then maybe we can get together and see who else we have to pick up.

Because, when I ask you not to let it go, I know the different items that always get on your priority agendas, but with some help and more hands lifting, it will make it a lot easier.

Mr. TOWNS. Thank you, very much, Congressman Rangel, and thank you, very much, Congressman Schiff.

At this time, I yield to Congressman Mica.

Mr. MICA. Thank you, Mr. Chairman.

As usual, Mr. Rangel, I think you really hit the nail on the head on some solutions for this. I spent part of yesterday reading the reports and see, today, some of the reports, and I think you went right to the heart of what we need to do.

Among the things that you mentioned was the enforcement. This report indicates very few are convicted and there are many negotiated settlements. Almost nobody goes to jail, as it appears.

And I was glad to see you also recommend to the committee that this be a felony and that these licenses be revoked and that we take some method, in spite of what any association wants, or otherwise.

My only question would be—and I agree with you on all of this—is in the report, which I just saw today, pages 20 and 21, it shows sort of a, another aspect of the problem, this broad jurisdictional responsibilities. And, it sort of looks like one of those games my 14-year-old plays, with all the different paths leading here and there, but very few seem to lead to conviction.

Would you support some sort of joint task force or some sort of authority, better authority for these agencies, both State and Federal, whatever, to pursue these matters? Do you have any recommendations on that?

Mr. RANGEL. In New York State, we've just had one heck of a team, without agencies vying for which one was going to have the press conference first.

I really don't know exactly what would work for the Nation. But, it would seem to me that if we can convince the administration to at least meet with the State people and share with them our willingness to support whatever task force they would want within the States, that might be a good beginning.

With us, with our county district attorney system, with our State prosecutor's office for Medicaid, with our attorney general, with our U.S. Attorney's office, we're OK. But, again, it's a question of resources. I mean, there's not a problem with a task force, but task

forces seem to have worked pretty successfully, as relates to drug trafficking law enforcement.

But, if we can have a conference with Members of Congress supporting it, I'm certain that those that are in the field would have better ideas as to the best way to attack this problem.

Mr. MICA. Thank you. Thank you, Mr. Chairman.

Mr. TOWNS. Let me thank you, again, Congressman Rangel, for coming, and I think that you have raised some very interesting points, and we look forward to working with you.

I think that the task force idea, working along with the caucus that you head, in terms of our working with you and be within that level, in terms of our own task force within the Congress, will sort of create the kind of atmosphere and climate to begin to continue to push, because I am concerned about the coordination, outside, as well, in terms of law enforcement.

I would just sort of feel that there might be a lot of waste, in terms of the fact that they're understaffed, but even with the staff that they have, there might not be the kind of coordination that's necessary.

I also feel that when I think about, as you indicated in terms of DEA—you indicated DEA has, what, 3,300——

Mr. RANGEL. No, less than 3,000 agents——

Mr. TOWNS. Less than 3,000.

Mr. RANGEL [continuing]. Men and women.

Mr. TOWNS. Well, you know, I really think they have a problem, because we almost have that many people guarding us in Washington.

Mr. RANGEL. You got that right.

Mr. TOWNS. So, I think that we need to really look at that, in terms of a commitment. I think that says, you know, that we're not doing all that we can do, and I think that we need to sort of push, in terms of all the agencies, to make certain that they have the resources to be able to go out and do the job that's necessary.

Because, as you pointed out, that we are losing money by not doing what's really right, and if we fund the agencies and have the coordination, then I think we can do a lot better.

So, thank you, very much, for calling it to our attention.

Mr. RANGEL. I'd like to say, in closing, that we might also consider a "Dear Colleague" letter, asking our colleagues that represent poor or communities that are hard hit with drugs, which of course would include the Hispanic and the Black Caucus, and to have them to identify for us those places that they know are flagrantly violating the law in their community. And then, we can coordinate, to make certain that at least the Federal Government knows where these sores are, and assist even more, to allow the local and State people to cut these cancers out of us.

Mr. TOWNS. Thank you, very much, for your suggestions.

Mr. RANGEL. Thank you.

Mr. TOWNS. Thank you, very much, Congressman.

Mr. RANGEL. Have a good hearing.

Mr. TOWNS. Thank you.

Mr. TOWNS. Our next witness, this morning, is the Associate Director of Health Financing Issues at the General Accounting Office, Leslie Aronovitz. Ms. Aronovitz is accompanied today by Audrey

Clayton from the Office of Financing and Policy at GAO, and Mr. Robert Hast, Assistant Director for Investigation, in the New York Regional Office, also of GAO.

Let me, before you take your seats, it's the custom of this office, the procedure is to swear our witnesses in, if you have no objection.

Will you please raise your right hand?

[Witnesses sworn.]

Mr. TOWNS. Take your seats.

I would like to welcome you to the subcommittee. Your complete testimony, without objection, will be included in the record. We would like for you to summarize, within 5 minutes, and allow the committee an opportunity to raise questions with you.

But, your entire statement will be included in the record.

So, Ms. Aronovitz, why don't you begin.

STATEMENT OF LESLIE G. ARONOVITZ, ASSOCIATE DIRECTOR, HEALTH FINANCING ISSUES, GENERAL ACCOUNTING OFFICE, ACCOMPANIED BY AUDREY CLAYTON, HEALTH FINANCING AND POLICY GROUP; AND ROBERT HAST, ASSISTANT DIRECTOR FOR INVESTIGATION, NEW YORK REGIONAL OFFICE

Ms. ARONOVITZ. Thank you, Mr. Chairman, and members of the subcommittee. We're very pleased to be here today to discuss Medicaid prescription drug diversion. At your request, we've been examining the extent of the problem, the reasons it persists, and initiatives to address it in the four most populous States: California, Florida, New York, and Texas. We have found that Medicaid, the primary source of health care funding for the poor, is vulnerable to drug diversion and that the difficulties involved in combating it are substantial.

Recent initiatives, in several States, show positive signs of stemming financial losses, but Federal leadership and support is still needed.

Medicaid is a logical target of drug diversion, because it typically includes prescription drugs in its covered services. In 1991, prescription drugs accounted for 7 percent of Medicaid spending, more than physicians' services, and more than any noninstitutional program benefit.

By 1996, prescription drug benefits are expected to reach $10 billion, nearly double the 1991 figure of $5.5 billion, which was pointed out by Congressman Mica earlier.

In Florida and Texas, the recent rate of increase has been even greater, with expenditures more than doubling between 1987 and 1991.

The incentive to abuse the Medicaid drug benefit is considerable. Some prescription drugs have psychological or physical effects similar to those of illicit drugs. Others have substantial monetary value, and profiteers can divert them for resale through illicit channels.

The pursuit of drug diversion in the Medicaid program entails a complex administrative structure. At the Federal level, HCFA, in the Department of Health and Human Services, administers and monitors the program. However—and this is really critical—HCFA

has no organizational unit dedicated to curbing fraud and abuse, nor is HCFA directly involved in drug diversion cases.

Each State administers the program through its own Medicaid agency. When fraud or some other intention wrongdoing is suspected, cases in most States are referred for investigation to organizationally separate Medicaid fraud control units, or MFCUs.

Directors of MFCUs in 20 States and the District of Columbia identified significant problems in their States, involving drug diversion. For example, some pharmacists routinely add medications to customers' orders, keeping the extras for themselves or to sell to others. Some clinics inappropriately provided Medicaid recipients with completed prescription forms that were then traded for merchandise in the store, or sold on the street to the highest bidders.

One head of one MFCU told us that some pills costing 50 cents at the pharmacy can be sold on the street for as much as $85.

In some cases, the schemes display characteristics typical of "pill mills," involving conspiracy among providers. For example, our own investigation revealed an organized network of colluding physicians, pharmacists, clinical lab owners, patient brokers, and middlemen, many of whom transferred money overseas through BCCI.

Program losses from this type of fraud can be significant. Though nationwide data are not available, New York's Social Services Department estimated that in 1990, "pill mills" and related schemes cost them $75 million, which was about 10 percent of their total drug benefit program.

Several factors complicate attempts to curb these schemes. Some relate to data inadequacies. Medicaid agencies typically do not have data available that are accurate, timely, and complete and in convenient form to highlight aberrant billing or referral patterns. For example, in California, a pharmacist was billing and being reimbursed by Medicaid for dispensing large volumes of drugs for more than 3 years—in many cases, more than 20 prescriptions a day for a single Medicaid recipient. Yet, the State's reporting system did not trigger an investigation of the pharmacist or of any of the recipients. A tip eventually led to disclosure of the scheme.

Staff shortages, in the face of lengthy and complex case preparation, hamper investigative agencies. And even those cases pursued as fraud, the outcome is often neither timely nor satisfactory. Few providers go to prison or lose their license, and a very small percentage of program losses are recovered.

In the four States that we reviewed, there were 39 drug diversion cases that the MFCU identified to us, and that were settled in 1990 or 1991. Most of these cases took at least 2 years to be adjudicated, professional sanctions were minimal and slow, and financial penalties were light. In more than half of these cases, restitution amounts were nominal—$5,000 or less. Small amounts of restitution are usually paid, but Medicaid only recovers a very small percentage of the larger-dollar settlements.

For example, in a case where restitution was set at $220,000, over 2 years ago, only $4,000 has been repaid, so far.

In addition, offenders frequently retain some connection with health care delivery. And, this is one of the more outrageous aspects. The most telling statistics came from the Florida Medicaid drug diversion cases.

Of nine individuals in Florida charged with fraud in 1990, five, including a pharmacist excluded from the program, are currently employed in pharmacies that are Medicaid providers.

Of five pharmacies charged with fraud in 1990, three were excluded from Medicaid. Yet, one pharmacist-owner sold his store but is still employed there as a pharmacist. In the other two, the pharmacies re-enrolled in the Medicaid program under new ownership, but one of those new owners is the spouse of the person who was convicted and thrown out of the program. And, this was not detected at the State.

Although Federal laws are in place to some extent, to exclude previously convicted providers from program participation, no one with authority and adequate resources is following up on these individuals.

We found that States are taking steps to address these problems. Recent initiatives emphasizing upfront controls include the use of identification cards that resemble credit cards, prescription filing systems that can instantly link orders to prescribing physicians, and data analysis techniques that can promptly identify physicians and patients prescribing or receiving high volumes of drugs.

Initiatives that focus on pursuit and punishment include establishing multiagency task forces, implementing stronger State laws and administrative procedures, and improving recovery of monetary losses by requiring high-volume providers to post performance bonds or other financial security as a condition of program participation. These measures appear to be achieving some success in New York.

Drug diversion continues, however. Many of the problems we found stem, in large measure, from severe resource constraints at the State and Federal oversight, investigative, and prosecutorial organizations. In the current budget environment, additional funding is difficult to achieve. So what we need to do—it's imperative that we make the best use of available resources.

Even still, there's no single entity that's orchestrating States' efforts to curb drug diversion, and we believe HCFA should assume this responsibility. In a report we issued today, that you all have referred to, we recommended that the Administrator of HCFA develop an overall strategy to address prescription drug diversion, an action that would highlight the importance of lessons learned from State initiatives.

One key element of such a strategy might be the designation of a unit within HCFA that could actually continually evaluate State initiatives that target prescription drug diversion and other Medicaid fraud, and provide guidance and technical assistance tailored to individual State problems.

Mr. Chairman, this concludes my testimony. We will be happy to answer any questions that you have.

[The prepared statement of Ms. Aronovitz follows:]

United States General Accounting Office

GAO

Testimony

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Committee on Government Operations
House of Representatives

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MEDICAID DRUG FRAUD

Federal Leadership Needed to Reduce Program Vulnerabilities

Statement of Leslie G. Aronovitz
Associate Director, Health Financing Issues
Human Resources Division

SUMMARY

Medicaid prescription drug fraud is widespread in the United States. Directors of Medicaid fraud control units, in 20 states and the District of Columbia, identified significant problems with such schemes. For example, some pharmacists routinely added medications to customers' orders, keeping the extras for themselves or to sell to others. Clinics inappropriately provided Medicaid recipients with completed prescription forms (scrips) that were then traded for merchandise from local pharmacies or sold on the street to the highest bidder. Some pills costing 50 cents at the pharmacy were resold for as much as $85.

A common scheme is the so-called "pill mill" in which physicians, clinic owners, and pharmacists collude to defraud Medicaid by prescribing and distributing drugs for the primary purpose of obtaining reimbursement. Patients are often knowing participants in these schemes, allowing use of their Medicaid recipient numbers for billing purposes in exchange for cash, drugs, or other inducements. GAO's own investigation revealed an organized network of colluding physicians, pharmacists, owners of clinical labs, patient brokers, and other middlemen, many of whom transferred money overseas through the notorious Bank of Credit and Commerce International.

Prescription drugs cost Medicaid $5.5 billion in 1991--more than it paid for physician services or any other noninstitutional benefit--and real spending per user for prescriptions tripled between 1975 and 1990. Drug fraud contributes significantly to these expenditures. Though nationwide data are not available, New York's social services department estimated that, in 1990, pill mills and related schemes cost them at least $75 million--about 10 percent of the state's Medicaid prescription drug expenditures.

States--struggling to curb diversion schemes--have instituted both up-front controls and measures intended to facilitate pursuit, punishment, and financial recovery. Some progress has been achieved. New York, for example, has experienced an 8-percent decrease in the number of Medicaid prescription claims during the past 5 years and a sharp reduction in spending for the most abused drugs.

Nevertheless, the problem persists. State officials told us that most leads are not pursued, cases take too long to resolve, and penalties are light even for those convicted. Most blame lack of adequate resources--a situation unlikely to be resolved in today's budget environment. Consequently, it is imperative to help the states use their resources as effectively as possible. The Health Care Financing Administration should display more leadership in developing an overall strategy to address prescription drug diversion and heighten states' sensitivity to the financial benefits of effective preventive measures.

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today to discuss Medicaid prescription drug diversion. At your request, we have been examining the extent of the problem, the reasons it persists, and initiatives to address it in the four most populous states: California, Florida, New York, and Texas. We have found that Medicaid, the primary source of health care funding for the poor, is vulnerable to drug diversion and that the difficulties involved in combating it are substantial. Recent initiatives in several states show positive signs of stemming financial losses, but federal leadership and support can help assure broader implementation of these initiatives to deal more effectively with this problem.

BACKGROUND

Prescription drug diversion has been a problem in the Medicaid program for at least the past decade. A common drug diversion scheme is the so-called "pill mill" in which physicians, clinic owners, and pharmacists collude to defraud Medicaid by prescribing and distributing drugs for the primary purpose of obtaining reimbursement. Patients are often knowing participants in these schemes, allowing use of their Medicaid recipient numbers for billing purposes in exchange for cash, drugs, or other inducements.

Medicaid is a logical target of drug diversion because it typically includes prescription drugs in its covered services.[1] It accounts for 80 percent or more of all federal spending on prescription drugs.[2] According to the Congressional Budget Office (CBO), real payments per user tripled for this benefit between 1975 and 1990.[3] In 1991, prescription drugs accounted for 7 percent of Medicaid spending--more than physicians' services and more than any noninstitutional program benefit.[4] By 1996, prescription drug benefits are expected to reach $10 billion, nearly double the 1991 figure of $5.5 billion.[5] In Florida and Texas, the recent rate of increase has been even greater, with expenditures more than doubling between 1987 and 1991.[6]

The incentive to abuse the Medicaid drug benefit is considerable: some prescription drugs have psychological or physical effects similar to those of illicit drugs; others have substantial monetary value, and profiteers can divert them for resale through illicit channels.

The pursuit of drug diversion in the Medicaid program entails a complex administrative structure. At the federal level, the Health Care Financing Administration (HCFA) in the Department of Health and Human Services (HHS) administers and monitors the program. However, HCFA has no organizational unit dedicated to curbing fraud and abuse, nor is HCFA directly involved in drug

diversion cases. Each state administers the program through its own Medicaid agency--variously situated in departments such as health, welfare, or human services--that is also responsible for maintaining program integrity.

It is not unusual for a drug diversion case to involve five or more state, local, and federal agencies during its investigation, prosecution, and resolution. In a case of provider abuse, state Medicaid agencies are authorized to take certain administrative actions. When fraud or some other intentional wrongdoing is suspected, cases in most states are referred for investigation to organizationally separate Medicaid Fraud Control Units (MFCUs). Some MFCUs have statutory authority to prosecute these cases; others must refer them to local, county, state, or federal prosecutors. Court probation offices can become involved to collect court-ordered fines, costs, and restitution.

Providers convicted of crimes involving Medicaid drug diversion are subject to various sanctions.[7] At the state level, the Medicaid agency may exclude them from the program for a period of time, and professional licensing agencies may suspend or revoke their licenses to practice in that state. Alternatively, they may receive lesser penalties--or none at all. Federal action may also be taken: the HHS Office of the Inspector General may--and in some cases must--direct HCFA to exclude the provider from participation in Medicare and other federal health programs. Also, the Department of Justice may seek substantial monetary penalties under the False Claims Act, or HHS may do so under the Civil Monetary Penalties provisions of the Social Security Act.

EXTENT OF THE PROBLEM

Directors of MFCUs in 20 states and the District of Columbia identified significant problems involving drug diversion (see fig. 1).[8] For example, some pharmacists routinely added medications to customers' orders, keeping the extras for themselves or to sell to others. Some clinics inappropriately provided Medicaid recipients with completed prescription forms (scrips) that were then traded for merchandise from local pharmacies or sold on the street to the highest bidder. Some pills costing 50 cents at the pharmacy were resold for as much as $85.

Moreover, in some cases, the schemes displayed characteristics typical of pill mills, involving conspiracy among several providers. For example, our own investigation revealed an organized network of colluding physicians, pharmacists, clinical lab owners, patient brokers, and other middlemen, many of whom transferred money overseas through the Bank of Credit and Commerce International. Figure 2 shows the structure of such a network.

Program losses from this type of fraud can be significant. Though nationwide data are not available, New York's social services department estimated that, in 1990, pill mills and related schemes cost them at least $75 million--about 10 percent of the state's total Medicaid expenditures for prescription drugs. The Federal Bureau of Investigation (FBI) has testified before the Congress on the continued existence in 1992 of such fraud in New York and other states.

WHY DIVERSION PERSISTS

Several factors complicate attempts to curb these schemes. Some relate to data inadequacies: Medicaid agencies typically do not have data available that are accurate, complete, timely, and in convenient form to highlight aberrant billing or referral patterns. Routinely generated reports fail to identify even obvious problems. For example, in California, a pharmacist was billing and being reimbursed by Medicaid for dispensing large volumes of drugs. For more than 3 years the volume of prescriptions was improbably high--in many cases more than 20 prescriptions a day for a single recipient--yet the state's reporting system triggered no investigation of the pharmacist or any recipients. A tip eventually revealed the scheme.

Staff shortages, in the face of lengthy and complex case preparation, hamper investigative agencies. Even for those cases pursued as fraud, the outcome is often neither timely nor satisfactory: few providers go to prison or lose their license, and a very small percentage of program losses are recovered. Consider the outcomes of 39 drug diversion cases settled in 1990 or 1991 in the four states we reviewed:

-- Most cases took almost 2 years to be adjudicated, once they were referred to the MFCU. Four cases took 4 years or more.

-- Professional sanctions were minimal and slow. Thirty-two cases involved providers with professional licenses. Six had their licenses revoked, three had them suspended, and four experienced only a 1-year probation. Almost one-third of these cases were still unresolved by licensing boards, an average of 44 months after first being reported to the MFCU. In one case, the entire scenario took 6 and 1/2 years--and the licensure action consisted of just a 1-year probation.

-- Financial penalties were light: in more than half the cases, restitution amounts were nominal--$5,000 or less. Providers usually paid these amounts. In cases in which courts set restitution at $20,000 or more, the Medicaid

agency recovered only a small percentage of the dollar amount established. For example, in a case where restitution was set at $220,000 on March 5, 1991, only $4,000 had been repaid as of July 12, 1993.[9]

Both state and federal agencies have other legal options for seeking recoveries. State Medicaid agencies can take civil action to recover estimated overpayments, but we found that they rarely do so when criminal charges are involved. Also, federal agencies seldom invoke the Civil Monetary Penalty Law (CMPL) or the False Claims Act, both of which allow severe financial penalties for filing unwarranted or unsubstantiated Medicaid claims. State and federal officials cited similar reasons for such inaction: scarce resources and the poor prospect of recovering substantial funds.

In addition, offenders frequently retain some connection with health care delivery, with the consequent opportunity for future violations. The most telling statistics come from the Florida Medicaid drug diversion cases.[10]

-- Of nine individuals charged with fraud in 1990, five--including a pharmacist excluded from program participation--are currently employed in pharmacies that are Medicaid providers.

-- Of five pharmacies charged with fraud in 1990, three were excluded from Medicaid. Yet one pharmacist-owner sold his store but is still employed there as a pharmacist, and the other two re-enrolled in Medicaid under new ownership (one of the new owners is the spouse of the convicted former owner).

Although federal laws are in place to exclude previously convicted providers from program participation, no one with authority and adequate resources is following up on these individuals.

STATE INITIATIVES ARE MEETING WITH SOME SUCCESS

States are taking steps to address these problems. All states have up-front controls designed to prevent Medicaid fraud. Since these are never 100 percent effective, states also have procedures for pursuit, punishment, and financial recovery. In their attempts to curb drug diversion, states have adopted a variety of approaches, and some federal initiatives are also assisting their efforts.

Recent initiatives emphasizing up-front controls include the use of identification cards that resemble credit cards, prescription-filing systems that can instantly link orders to the

prescribing physician, and data analysis techniques that can promptly identify physicians and patients prescribing and receiving high volumes of drugs.

Initiatives that focus on pursuit and punishment include establishing multiagency task forces to coordinate case development, implementing stronger state laws and administrative procedures to expedite disciplinary actions, and improving recovery of monetary losses by requiring high-volume providers to post performance bonds or other financial security as a condition of program participation.[11] These measures appear to be achieving some success, particularly in New York. Moreover, these state initiatives are effective against both prescription drug diversion and other associated types of Medicaid fraud.

Some federal measures also support states in these endeavors. Regulations require states to engage in various monitoring activities. Most recently, the Omnibus Budget Reconciliation Act of 1990 required states to develop a drug use review system for Medicaid recipients and implement it by January 1, 1993. While the primary purpose of this legislation was to improve the quality of health services through counseling and prospective and retrospective medication assessments, it will likely deter fraud and provide early warning of violations. The law provides for screening for clinical abuse/misuse and optional electronic claims processing.

In at least one state, the combination of up-front controls and "pay-and-chase" initiatives--aimed at facilitating pursuit and punishment--has been linked to measurable reduction in abuse of Medicaid's prescription drug benefit. New York has experienced an 8-percent decrease in the number of Medicaid prescription claims during the past 5 years and a sharp reduction in spending for the most abused drugs.

EFFORTS INSUFFICIENT WITHOUT ADDED SUPPORT

Drug diversion continues, however, in many areas of the United States. Both state and federal officials cite lack of adequate resources as the primary reason their efforts have failed to control this type of fraud or to recoup the dollars lost to the program. While some states claim partial success, most leads are still not pursued. In Florida, for example, the MFCU rejects more than 90 percent of the state Medicaid agency's referrals because of its own staffing constraints. This leads to a no-win situation: Medicaid agency personnel are reluctant to invest a lot of effort developing cases that are likely to be rejected, and MFCU officials are more likely to reject ill-prepared cases because of the additional burden imposed on their own limited staff. In each state we visited, officials expressed frustration at how long it

takes to resolve each case, at the poor and uncertain outcome, and at the prevalence of repeat offenders and resilient schemes. As I pointed out earlier, cases drag on for years, almost no one goes to prison, and many offenders retain their connection with the health care system--sometimes even continuing as Medicaid providers--with consequent potential for further violations.

CONCLUSIONS

States' emphasis on developing preventive measures is well placed because efforts to recover losses are seldom successful. Promising initiatives include tighter controls on provider enrollment, utilization limits, electronic verification of claims, and earlier and more sophisticated analyses of claims data.

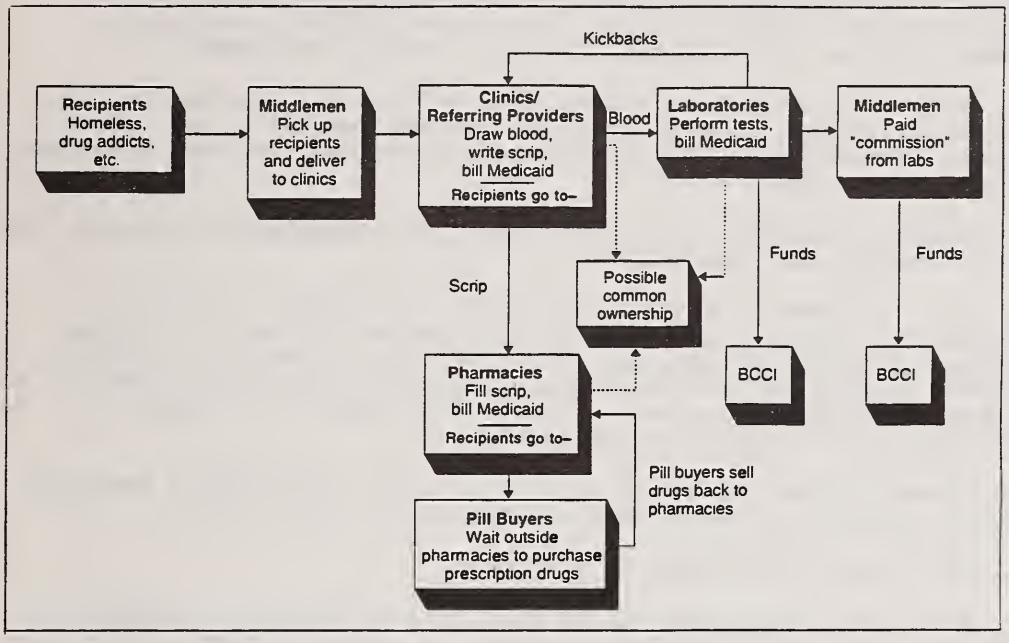
States have also recognized the need to supplement prevention with added support for investigation, prosecution, enforcement, and recovery efforts. As a part of this undertaking, they have encouraged increased cooperation among agencies--an approach that is especially important in addressing highly organized networks designed to divert drugs and engage in other fraudulent health care schemes. Despite these initiatives, Medicaid drug diversion remains widespread and persistent, suggesting that state agencies could use help from HCFA in controlling prescription drug fraud and related abuse.

Many of the problems we found stem in large measure from severe resource constraints in the state and federal oversight, investigative, and prosecutorial organizations. In the current budget environment, additional funding may be difficult to achieve. Consequently, it is imperative to make the best use of available resources. Although no single entity is orchestrating states' efforts to curb drug diversion, we believe HCFA should assume this responsibility. In a report issued today, we recommended that the Administrator of HCFA develop an overall strategy to address prescription drug diversion, an action that would highlight the importance of lessons learned from state initiatives.[12] One key element of such a strategy might be the designation of a unit within HCFA responsible for (1) conducting continuing evaluations of state initiatives targeting prescription drug diversion and other Medicaid fraud, and (2) providing guidance and technical assistance tailored to individual state problems.

Mr. Chairman, this concludes my testimony. I will be happy to answer any questions that you or members of the Subcommittee may have.

Figure 1: State Medicaid Fraud Units Citing Pill Mill Problems

Figure 2: A Composite Pill Mill Network in New York



NOTES

1. Although coverage of prescription drugs under Medicaid is optional, all states provide the service, albeit with some restrictions. Some states require a nominal copayment.

2. HCFA officials cited a figure of 80 percent. Independent calculations led to a value of 86 percent for 1991, but, since these involved data from two different sources, we have presented the lower estimate here.

3. Factors Contributing to the Growth of the Medicaid Program, CBO Staff Memorandum (May 1992).

4. This is based on HCFA data quoted in an article by John K. Iglehart, "The American Health Care System: Medicaid," The New England Journal of Medicine, Vol. 328, No. 12, March 25, 1993. "Total computable" Medicaid data released by HCFA would lead to a lower value of 6.2 percent. This still exceeds all other noninstitutional spending categories.

5. These figures are based on HCFA's "total computable" Medicaid data, relative to total Medicaid spending of $88 billion.

6. GAO computation based on HCFA data.

7. Some civil sanctions may be applied even when the offender is not convicted of a criminal offense. A lesser burden of proof may apply in such instances.

8. We surveyed 42 MFCU Directors from 41 states and the District of Columbia. Other states lack separate units dedicated to the pursuit of Medicaid fraud.

9. This was revealed during the course of our investigation. State Medicaid officials and court probation officers said they lacked sufficient personnel to keep track of payments due.

10. When GAO brought these situations to the attention of Florida Medicaid officials, they said that either they were not aware of their status or they had not yet determined whether terms of exclusion had been violated. Under some conditions, an excluded individual may be connected with a participating facility in a limited capacity.

11. In New York, where this approach has been adopted, a high-volume provider is defined as one with anticipated Medicaid billings exceeding $500,000 a year.

12. Medicaid Drug Fraud: Federal Leadership Needed to Reduce Program Vulnerabilities (GAO/HRD-93-118, Aug. 1993).

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Mr. TOWNS. Thank you, very much, for your testimony.

Let me begin by what is it—what is it we can tell—I guess, let me put it this way: Why is it so difficult to put these pharmacists out of business, that we know are involved in illegal activities and have been doing it for quite some time, but we have great difficulty in putting them out of business. Why does it take us so long to do that?

Ms. ARONOVITZ. It's a great question, and it's a very frustrating answer.

In a lot of cases, pharmacists will distance themselves from the actual fraud that occurs. Very often, when a pharmacy is being investigated, the counter clerk or some other employee in the pharmacy ends up being the one that's associated with the fraud, and ends up taking the conviction or the rap.

When a pharmacist is convicted, and even if the pharmacist is excluded from the program, nothing prevents this person from continuing to have a financial interest in a pharmacy and just not disclosing it. There's a very good chance that will not be caught.

Or, the pharmacist could reopen in the same or a different location, under a different corporate entity. And, there's a very high probability that would not be detected.

Even if such a procedure is against State law, States don't have time or resources to pierce the corporate veil, to get to the pharmacist or to the owners and directors of the pharmacies. Also, a pharmacist who's convicted of Medicaid fraud has a high probability of keeping his or her license. We found, in the States we visited, that pharmacy boards or professional licensing boards very often would like to evaluate the entire practice pattern of a professional and sometimes the few charges against a particular pharmacist would not be enough to color their overall conclusion that this pharmacist is basically doing an OK job.

So, they're very hesitant to go ahead and be aggressive in that area. And also, we found that professional licensing boards, if they do take action, take it very, very late and usually would probably only give probation.

So, it's not a positive picture.

Mr. TOWNS. Let's switch roles for a moment. If you were a member of the U.S. Congress, what would you recommend? What would you do?

Ms. ARONOVITZ. I think it's such a very important issue, to the extent that States are struggling with this all the time.

The situation varies so much in different States, that they have to come up with what they would consider a solution that would be in line with their legislative philosophy in that State and the legislative framework in that State.

We would like to see a strategy for States, rather than specific initiatives, that would emphasize upfront controls. One of the hardest things to do, in any kind of government program, when there's overpayments—not necessarily fraud, but it's even more difficult when there is fraud—is to have to collect money at the back end—"pay and chase"—to go after people after the program has spent the money.

So, we feel very strongly that if you have upfront control that tries, before money ends up ever getting paid to a provider, tries

to screen out these kinds of schemes or identifies aberrant billing, then you're way ahead of the game.

But controls, any kind of upfront controls, are not 100 percent reliable, so you have to have certain strategies that deal with the pursuit and punishment of people accused of fraud also.

New York has a very interesting and a very powerful tool in its electronic eligibility verification system, coupled with its service thresholds. What that means is, when a Medicaid recipient's number gets called in for a prescription, let's say, the pharmacist, before they fill the prescription, must check that that person is actually eligible to receive those benefits. That person has a service threshold, which means that they could only get a certain number of prescriptions per month. So, you couldn't have the situation in New York, theoretically, that you would have in California where you had what we described earlier, where a particular recipient was receiving 20 or 30 prescriptions a day.

It's those kinds of upfront controls that could really move forward in trying to identify the problem or make a dent in the problem.

On the back end, you also want a balanced strategy, focusing on the pharmacist, on the physician, other types of providers, and also on the recipient itself.

And here, again, New York has a very interesting program, which is not common in very many States. It's where, if there's a suspicion that a particular recipient's number is being used to a great extent, they could lock a recipient into a particular pharmacy or a particular provider, to get medical services. They do it as much not to prevent fraud as to assure that that particular recipient actually has access to a provider who is giving them legitimate medical care.

But, what it also does is it forces the recipient to do all their business in one particular location, so that the level of services provided to that recipient could be controlled a lot better.

So, it's these kinds of activities—both upfront and in the back—that will go far to try to let the provider community and the recipient community know that the State is aware and is being aggressive, and we think that's necessary in every single State.

Mr. TOWNS. All right. Thank you, very, very much for your very eloquent testimony.

At this time, I would like to yield to the ranking member of the subcommittee, the gentleman from Albuquerque, NM, Congressman Schiff.

Mr. SCHIFF. Thank you, Mr. Chairman, and thank you, Ms. Aronovitz.

There are two things I'd like to ask you about. The first is, when you describe all of the problems and difficulties in investigating and prosecuting these cases, and other sanctions, I understand all of that, except, and I think it may be the weak link, and that is the lack of professional sanctions, if I hear you correctly. In other words, if I understand you correctly, the pharmacists who are found to have been involved in this kind of fraud usually do not lose their licenses? Do I hear you correctly?

Ms. ARONOVITZ. Right, yes, that's correct.

Mr. SCHIFF. Could you, perhaps, go back over that again? Your experience, from your investigations, why that is the case? Or why it isn't the case?

Ms. ARONOVITZ. Professional licensing boards have a lot of different priorities in terms of how they want to proceed with just license, just licensing professionals in their State. Every State Licensing Board has their own priorities.

And, what I was stating before is that even though, theoretically, when someone is convicted of fraud, you would expect that the State Licensing Board would take action, at least review that case and decide whether they deserve to continue to practice in the profession. In reality, in many States, and particularly some of the ones we went to, we find that licensing boards have either other priorities or they have other criteria they use in terms of kicking someone out or revoking or suspending a license. And, that it would take a severe type of activity to actually suspend or revoke a license, more severe than what a licensing board would look at as a Medicaid problem.

Mr. SCHIFF. I regard fraud as pretty severe.

Ms. ARONOVITZ. So do we.

Mr. SCHIFF. Well, I wonder if it is possible to put in the law, as the system exists today, some type of requirement that State professional boards take further action when there is proven complicity in Medicaid fraud. I don't know how specific you can be on that, because every case is an individual case, but——

Ms. ARONOVITZ. It's—the State Licensing Boards are really subject to State regulation and, therefore, it would have to be a State initiative.

Mr. SCHIFF. That's true, of course, but they get our Federal money.

Ms. ARONOVITZ. Yes, that's true.

Mr. SCHIFF. Right there, we can have discussions with them about that.

Ms. ARONOVITZ. Absolutely.

Mr. SCHIFF. Because, as I can tell you, when I was a prosecutor, the Inspector General's Office of HHS came by and wanted to know how many cases we were prosecuting out of State and local county district attorney's offices. They didn't say well, you're local, so we have nothing to do with you.

Ms. ARONOVITZ. Right. That's absolutely true.

Mr. SCHIFF. So, I wonder why the—I'm wondering out loud, I guess.

Ms. ARONOVITZ. Sure.

Mr. SCHIFF. I know you're not responsible for this.

I wonder why they can't pay that same visit to the professional licensing boards?

Ms. ARONOVITZ. Absolutely. And we think that the licensing action is just one of a whole series of activities that, really, should revolve around a particular convicted person who's participating in the program.

Mr. SCHIFF. Absolutely.

One other thing I'd like to ask you: We have referred to this problem around the Medicaid program. To the best of my knowledge, Medicare does not provide prescription drug funding.

Ms. ARONOVITZ. On the whole, it does not.

Mr. SCHIFF. Correct, and there's exceptions. I understand that. But, at least one other program does—two other programs, the military——

Ms. ARONOVITZ. Right.

Mr. SCHIFF [continuing]. Provides prescription drugs, and the Veterans Administration provides prescription drugs. I understand that sometimes there can be a charge for these, and that's a separate issue. But, if not government provided, it's certainly heavily government supported.

Do we have these same kinds of problems that you know of in these programs? That is, are there those tied into the Veterans' system who operate this kind of fraud, also, or the military?

Ms. ARONOVITZ. We haven't looked at that in this study, and we plan to check, but one thing that is incredibly enlightening: When we started, when we embarked upon this area, we found that 80 percent of all drug spending at the Federal level is in the Medicaid program. I was very surprised at that.

So, we're saying that all other Federal agencies that have a drug benefit would comprise only 20 percent of the Federal money, and that would be Champus, it would be VA, and Defense, and also Indian Health Service or some of the others.

So, to the extent that the program funds are much smaller, their efforts might be much smaller, but we're really not aware of some of those initiatives, but Audrey might know of some things.

Ms. CLAYTON. Yes, as Leslie said, we did not look at that in this program. However, I am aware of other GAO reports. They have found considerable prescription drug diversion in VA Hospitals, though it takes a different form because of the set up of the benefits, than it does with Medicaid.

Mr. SCHIFF. Well, let me come back to that figure that 80 percent of Federal prescription drug funding is in the Medicaid program.

Ms. ARONOVITZ. Right.

Mr. SCHIFF. What percentage, to the best of your knowledge, of the recipients of this program are in Medicaid, versus the number of individuals who are in military or VA services? Somehow, I don't think it's 80–20.

Ms. ARONOVITZ. No, I think your intuition is probably correct. It's something we will look into.

Mr. SCHIFF. That wouldn't take a rocket scientist.

Ms. ARONOVITZ. We don't know that—right.

Mr. SCHIFF. But it certainly suggests, not that fraud doesn't exist in the other programs, to an adapted kind of system, but that the bulk of the fraud is in the Medicaid recipients.

And, I would wonder—again, I'm wondering out loud why that would—if that's true, and it certainly just looking offhand at the figures would indicate that—I wonder if it's because—well, maybe I'll just drop it at that. You know, I guess we can all surmise why it might be the case, but it certainly—if I'm correct that there's a tremendous imbalance, which is not otherwise explained and maybe can't be explained through other reasons, and the imbalance is not an imbalance, but it certainly suggests a huge—I mean, if you try to look at the per capita use of prescription drugs, of those who receive a Federal benefit, if it's so much higher in the Medic-

aid program than the other programs and you can't come up with a rational explanation for that, it sure sounds like "Katie, bar the door," and what's going on over there, it seems to me.

Ms. ARONOVITZ. Yes. It's something, I think, we'll pursue more.

Mr. SCHIFF. Thank you. I yield back, Mr. Chair.

Mr. TOWNS. Right. Thank you, very much.

At this time, I would like to yield to Congressman Mica from the great State of Florida.

Mr. MICA. Thank you, Mr. Chairman.

Ms. Aronovitz, you were talking about Florida and I didn't catch all of it. Was that nine pharmacists that were—were they convicted, and was that of fraud, and you said five were still practicing?

In fact, I want to make sure I get a copy of your testimony. Is it in the report?

Ms. ARONOVITZ. Yes. It's on page 18 of our report, and it's at the top of the page. It's the two bullets: Of nine individuals charged with fraud, five——

Mr. MICA. OK. They weren't convicted, or——

Ms. ARONOVITZ. They were charged with fraud in 1990, and they were convicted.

Mr. MICA. And convicted.

Ms. ARONOVITZ. Yes.

Mr. MICA. Was that under Federal statute, do you know? And was that under—I guess there's two Federal statutes—the False Claims Act, as I said, and also the Civil Monetary Penalties Law——

Ms. ARONOVITZ. Monetary Penalties Law, right.

Mr. MICA [continuing]. Under Social Security, or, I guess, it could be some other fraud that they——

Ms. ARONOVITZ. Right, yes, it could be.

We will check for you, if you'd like.

Mr. MICA. Because, you know, I know the problem with the States and the States that regulate their professions and to fight that battle is almost impossible because there's such a tight, you know, network between the professions and the legislature. Having served there, I know some of those relationships.

But, if you'd have a Federal penalty—well, first of all HCFA does not have an enforcement unit, is that correct?

Ms. ARONOVITZ. Right. They're not even organized in a way that they could, really, be on top of fraud and abuse, any kind of Medicaid fraud and abuse.

They do have a more organized approach in the Medicare program, but not even in Medicare, not to the extent that we would probably like.

Mr. MICA. Well, what is it, the MCF?

Ms. ARONOVITZ. U. MFCU, the Medicaid fraud control unit.

Mr. MICA. Who is that under?

Ms. ARONOVITZ. That's an organizationally separate State organization that works in conjunction with the Medicaid agency, that receives referrals where there's possible fraud involved, and they're usually housed in the attorney general's office, in most States.

Mr. MICA. Well, we do have, then, some provision under which these people can be charged——

Ms. ARONOVITZ. Yes.

Mr. MICA [continuing]. At the Federal level. So, I wanted to find out, one, whether we had, you know, the proper authority. And then, two, the question comes up, staffing.

Is the problem with the staffing—what part of enforcement? Is this part of it unclear jurisdiction and diffused authority, or is it all money? Maybe you could break it down. You know, do you think it's 50–50 or——

Ms. ARONOVITZ. I think the overwhelming problem that we confronted in any State, in every State organization and at the HHS IG's office was resource shortages. It's a problem both in the MFCUs and in the OIG's office.

Let me give you some numbers that would——

Mr. MICA. But these cases also took at least 2 years, 50 percent of them, I think, to pursue. Is that because of the complexity, the complex nature of the defense?

Ms. ARONOVITZ. Well, it's the limited resources and the complex nature and also, it's a very arduous process. Data systems are not always electronic, and in a lot of States there's a lot of manual effort involved in putting these cases together.

Mr. MICA. That was going to be my next question.

Do you think electronic processing in all these States would help resolve that? I know IRS can find, in hundreds of millions of transactions, if I don't report $18 of interest from my kid's account. It's under my Social Security No. They pick it up like that.

Ms. ARONOVITZ. Right.

HCFA does have a management information system and requires States to have such systems that actually have the claims data, in some form, at the State level. But, it's not user-friendly and it's not in formats that allow one to readily identify problems.

So, for instance, if you had one recipient that was going all over town, receiving five prescriptions in each place, the data wouldn't—necessarily, show, easily, that this one recipient received 300 prescriptions that day.

In other words, it takes a lot of resources at the State level to manipulate the data in such a way that it ends up being useful and telling, and HCFA needs to work with the States to help them identify different algorithms that could give the States a lot of hints, better hints, quicker.

Mr. MICA. One final question, Mr. Chairman, if I may.

I understand we have laws now, on the books, Federal laws, and I guess that would be conviction of a felony under the False Claims Act. If you're convicted of that, is there no prohibition to keep people from participating in the system?

Ms. ARONOVITZ. Audrey, would you like to answer that?

Ms. CLAYTON. Yes. The short answer is yes. If they are convicted of a criminal fraud under Federal laws, they are excluded.

Mr. MICA. Well, how about these five dudes from Florida?

Ms. CLAYTON. Well, these cases were all, as it happens, convicted under State fraud—State Laws.

Ms. ARONOVITZ. But, it's interesting, even though a provider must be excluded from the program, it doesn't always mean that they can't come back, either behind the scenes or with a small own-

ership interest or come back and just not get detected by the States.

Mr. MICA. Thank you, Mr. Chairman.

Mr. TOWNS. All right. Thank you, very much.

Let me ask, before you leave, I have a couple of more things. Could you bring those charts around, spin those charts around so we could see them?

And let me ask you, which is not a part of the question to you today, but based on your experience, especially Ms. Clayton, who has been involved in this for so many years. I want to take this opportunity to sort of ask a question, in reference to the coordination.

Congressman Rangel talked about it and I still almost have in my head that I see all kinds of things happening. I see, probably, a U.S. Attorney locking up DEA, and DEA locking up U.S. Attorney, almost, because of the fact that everybody is sort of looking at the same thing, not knowing in terms of what the other one is doing, and that a lot of energy and time is being wasted, and all of a sudden they find that this person is also involved in law enforcement.

And I just sort of wondered if there is any pattern in terms of where there is no coordination that more resources are being wasted and where there is some kind of communication, that a better job is being done with a limited amount of resources?

We'll move those after you finish, you know. I know anybody can see, but we wanted the members to see that.

Ms. ARONOVITZ. Did you want me to explain the charts?

Mr. TOWNS. Yes, and also to respond to the question, yes.

Ms. ARONOVITZ. We'll respond—Audrey, did you want to start?

Ms. CLAYTON. Yes. We don't have outcome measures that could link better results with better coordination, I'm afraid. Just anecdotally, we are finding coordination efforts are increasing in the States, not only among Federal and State governments and between the different State agencies, but also many of these schemes also affect private insurance companies, and we did find an increased number of task forces and we do believe that this is helping to address the problem.

But, we do not have any data that would support that. It's purely our impression.

And it varies tremendously from State to State. Not only the laws enter into it. Some State officials told us they had a perception that they should not coordinate too closely. It might jeopardize standards of evidence or privacy laws, if they shared too much information, and personalities enter into it, too, as they do in terms of everything.

Ms. ARONOVITZ. In terms of the—this is interesting. We think it's very important that, at the State level, the Medicaid agency and the MFCU coordinate very closely, also with the courts and prosecutors and other parties. The Medicaid agency is the regulatory agency. They have a pretty different agenda, in terms of administering the program, trying to keep it going, trying to make sure that people get good health care. They're looking at quality, and they're looking at a lot of the program administration aspects.

On the other side, the MFCU, its charter is to assure that it could convict people who have been charged and proved to be fraudulent. When you have the different goals and different agendas, you don't always have a natural meeting of the minds. And, therefore, in some States, we noticed that it's not that easy for States to coordinate and share information.

One thing that was fascinating in Florida was that we wondered why the Medicaid agency wasn't, why they were being frustrated in developing cases or identifying additional fraud, and they told us that the MFCU in Florida only has resources to accept about 10 percent of their referrals right now, so 90 percent of all the referrals from the Medicaid agency or the leads that the Medicaid agency finds ends up not getting investigated by the MFCU.

So, it's very demoralizing for the Medicaid agency. At the same time, the Medicaid agency isn't always developing the cases enough, to meet the needs of the MFCU because they realize that in most cases they're not going to even be accepted.

We're very concerned about the funding levels for the OIG and also any attempt to try to limit or cut the Federal match for MFCUs. This was a proposal quite a few months ago, that does not seem to be part of the reconciliation package right now, but it's still something in the back of the minds of some of the administration officials, and that is the proposal to cut MFCUs to 50 percent matching Federal funds. Right now, MFCUs get 75 percent matching.

We found out that $10 billion of Federal matching money was not claimed by the MFCUs last year, because they couldn't come up with their 25 percent share. So, there's $10 million already out there, that's not being used.

So, we are really hoping that people don't look at program safeguards in a shortsighted way, to ratchet down administrative costs, without really understanding what effect that will have on program dollars.

Mr. TOWNS. Right. Thank you, very much.

Do any of the members have any questions on the charts that are before us?

Mr. SCHIFF. Mr. Chairman, I can't quite see the labeling. I assume the dark color means "reporting a greater problem"?

Ms. ARONOVITZ. Right.

The white States—States in white, have MFCUs, but they felt that there wasn't a big problem in their State. The ones, the darkest colors are the States that have MFCUs, that felt that there was a very big problem. And that's about half the States.

And then, the other ones, they don't have a separate MFCU in their State. That's the lightly shaded.

Mr. SCHIFF. I think Congressman Mica wishes to be recognized, but can I followup just with a question on that chart?

The pill buyers—can you explain—I think we all understand what's going on here, but I guess the buyers can be bribed, including the pharmacist that dispenses might buy them back at a cheap cost. But, I guess there's a market out on the street, if they're an illegal narcotic type of substance? And I've heard there's even a market overseas.

Can you go into that just a little bit? Who are the buyers of these pills?

Mr. HAST. Really, every one that you have just mentioned.

Mr. SCHIFF. All of the above.

Mr. HAST. All of the above. There are various markets for narcotics. For prescription drugs that are not illegal or narcotic, but do have a market, some of them are being sent and shipped overseas. As Congressman Rangel had said, there's a market in the Dominican Republic. There is a large market in Cuba for drugs that have been shipped from the United States.

They're also being resold to the pharmacies at a cut rate, where they're paid for by Medicaid at a certain rate, passed around through a warehouse, and then sold back to pharmacies. There have been some prescription drugs found in pharmacies that have been sold enough times that the expiration date for their value to a recipient is expired, and they are no longer able to perform the function that they were supposed to perform.

But there are a number of different buyers for these pills. Some of them on the street do have a narcotic effect and can be sold at a much higher price on the street than they are sold through prescriptions.

Mr. SCHIFF. Thank you, Mr. Chairman. I yield back.

Mr. TOWNS. I yield to Congressman Mica.

Mr. MICA. Just a quick question, if I may.

Can you explain the problem in the funding of the units, the MFCU units? For example, in Florida, is that because they are, they don't have the 25 percent match? Is it because the Federal Government doesn't say that, you know, you must have this type of activity, enforcement activity in place in order to participate? Or is it because the Federal match isn't available?

If you'll let me indulge myself here for a response?

Ms. ARONOVITZ. Quite a while back, when the MFCU program started—and, by the way, the legislation that created MFCUs was really modelled after New York's program—we were very curious, and we had a request to find out why more States weren't organizing MFCUs, separate organizational structures. And, there were a whole bunch of reasons.

In some cases, the State, itself, felt that it had other priorities, and it didn't need to have a separate unit for Medicaid fraud.

And, in some cases, the States felt that they had sufficient investigative resources existing already in other departments or other units in the State, and didn't need a separate organization.

So, there are several reasons. Nowadays, it would pretty much be a lack of resources.

Mr. MICA. Is there a Federal requirement that they must have a unit in place?

Ms. ARONOVITZ. No. There's not a Federal requirement that the State must have an MFCU.

Mr. MICA. OK, and they can apply for funds, then, the 75 percent matching. Are there enough funds available to fund all the requests, or not?

Ms. CLAYTON. Yes. In order to get Federal funding, the States have to have an organizationally separate Medicaid fraud control unit; separate, that is, from the Medicaid agency.

And, 40 States and the District—no, DC is not recognized, excuse me; 41 of them do.

I guess there could be a theoretical problem that there might not be Federal funds available. The specific one we were referring to here is Federal funds were available. Of that $10 million was not claimed by the States because they did not have their own funds to come up with their 25 percent match.

Ms. ARONOVITZ. We have not heard of a problem where the Federal Government was unable to fund States at the 75 percent level, if a State became eligible for those moneys.

Mr. MICA. Thank you, Mr. Chairman.

Mr. TOWNS. Thank you, very much.

Let me thank you for your testimony. It's been very informative and we look forward to working very closely with you in the days and months ahead to try to improve this situation. I think that we would all agree that there's too much waste and it's going to require everybody working together to resolve that problem.

Thank you, again.

Ms. ARONOVITZ. You're very welcome. Thank you.

Mr. TOWNS. Our next witness today is Shirah Neiman, deputy U.S. attorney for the southern district of New York.

Ms. Neiman, it is the custom of the subcommittee to swear in the witnesses.

If you would stand—of course, you're standing.

[Witness sworn.]

Mr. TOWNS. Take your seat.

Ms. Neiman, I would like to welcome you to the subcommittee. Your complete testimony will, without objection, be included in the record, and please proceed to summarize your testimony within 5 minutes, which will allow the members of the subcommittee to raise questions.

So, you may proceed.

STATEMENT OF SHIRAH NEIMAN, DEPUTY U.S. ATTORNEY, SOUTHERN DISTRICT OF NEW YORK, ACCOMPANIED BY SUSAN BRUNE

Ms. NEIMAN. Thank you, Your Honor.

Mr. Chairman and members of the subcommittee I am pleased to be here today to talk about what we at the U.S. attorney's office has learned while investigating and prosecuting prescription drug diversion in the southern district of New York.

Our office has recently concluded two significant prosecutions of prescription drug diverters. The first of these, a group of cases known collectively as "the Goldpill case," traced diverted noncontrolled prescription drugs from Medicaid recipients through several levels of illicit distribution and ultimately to the unsuspecting consumer.

The second case, United States against Khan, focused on a chain of clinics that paid Medicaid recipient "patients" for their participation in a large-scale fraud on Medicaid by providing patients with bogus prescriptions.

In the scheme that was the focus of the Goldpill and Khan cases, Medicaid recipients obtained prescriptions for drugs, usually particularly expensive drugs, that they did not intend themselves to

take, and filled them at pharmacies at taxpayer expense. The Medicaid recipients then illicitly sold these drugs to street-level diverters, also known on the street as "non men." Ordinarily, the street-level diverters sold the drugs to high-level diverters, who in turn sold them to other high-level diverters, or directly to pharmacies.

Pharmacists at the purchasing pharmacies who bought the drugs at a discount from the price they would have had to pay legitimate suppliers, then dispensed the diverted drugs to the public.

The Medicaid recipients and drug diverters frequently remove the drugs from the original bottles in which they had been dispensed, and repackaged them in plastic bags and other containers. In other instances, diverters using counterfeit labels and safety seals, repackaged the drugs. As a result, consumers were put in jeopardy of receiving unsafe drugs, because the diverted drugs were frequently dispensed to consumers without the benefit of accurate information about the drugs. In particular, these drugs often lacked accurate expiration dates, which are necessary to monitor a drug's potency, and lot numbers, which are necessary in case of a manufacturer's recall.

In addition, the diverted drugs were often stored by drug diverters under conditions that were unsanitary and that were not temperature controlled, thereby posing further risk to the consumers who ultimately were dispensed these drugs.

In the Goldpill case, physicians' samples were another source of prescription drugs. The samples, which are given to doctors and others for free, to promote the sale of the drugs, were illegally sold for profit. All marking and packaging indicating that the drugs had been designated as samples were removed. Where the word "sample" was stamped on individual pills, diverters went so far as to scrape it off, pill by pill.

In the process, all the labeling indicating the expiration dates and the lot numbers were removed from the pills. The same risks to consumers were posed as with the drugs that were bought by the Medicaid patients from the clinics.

Let me tell you about the Goldpill case and how it was developed. The first real break came in the summer of 1991, with the arrest of a person who later became a cooperating witness and who I will refer to as CW1. Based on a tip from a confidential informant, the FBI and Food and Drug Administration agents surveilled a Bronx health and beauty aids store owned by CW1. Based on that surveillance and on the information supplied by the informant, search warrants were obtained for the store and for CW1's residence. The agents found $500,000 in cash, at CW1's residence.

CW1 admitted that he had a stash house for diverted drugs in the Bronx, and allowed the agents to search it. There, the agents found a collection of diverted drugs valued at $1 million. Most of the drugs were loose, in open plastic tubs. Nearby were thousands of prescription labels that appear to have been removed from prescription bottles, scraping tools, a pill counter, counterfeit manufacturer's labels, and counterfeit safety seals.

In the face of this evidence, CW1 began to cooperate. He admitted that he had been in the drug diversion business for 4 years. During that time, he had built up a roster of a dozen individuals,

street-level diverters who supplied him with drugs that they, in turn, had bought on the street from Medicaid recipients. CW1 bought the drugs loose, in prescription vials, in counterfeit packaging, and even in original manufacturer's packaging. He, thereafter, sold the drugs primarily to a high-level diverter who was an important target because it was he that could lead us to pharmacists and other high-level diverters. Since he, too, ultimately became a cooperating witness, I will refer to that high-level diverter as CW2.

The investigation then focused on building cases on the street-level diverters who supplied CW1 and on CW2. It was simple to gather evidence on the street-level diverters. We just sent CW1 out on the street with an FBI undercover agent and he continued buying diverted drugs.

Gathering evidence on CW2 was much more complicated. We didn't want to sell tainted drugs to CW2. So, the FBI, together with the FDA and with an FBI pharmacist made legitimately obtained drugs appear to be diverted by altering the packaging, messing them up a little bit so they looked kind of dirty, removing inserts from the packages, breaking safety seals, and removing part of the labels. Occasionally, to maintain his credibility with CW2, CW1 also sold loose prescription drugs, again under the agents' supervision. In all instances, to minimize any danger to consumers, only those drugs with relatively distant expiration dates and stable compositions were selected and their lot numbers were recorded and filed with the FDA.

In January 1992, there was a significant breakthrough. We gathered enough information to arrest and search a rental storage locker CW2 maintained on Long Island. The locker, which lacked ventilation and temperature controls, contained a large inventory of diverted drugs.

CW2 began to cooperate. He said that for 5 years he had been in the business of buying and selling diverted drugs. He sold the drugs he obtained from CW1 to five pharmacies and to three other high-level diverters—Stanley Jacobson, Martin Bobb, and Donald Solof.

Under the agents' supervision, CW2 began making a series of reverse sales, that is selling to Jacobson, Bobb, Solof and his pharmacist customers apparently diverted drugs that the agents prepared. In the meantime FBI surveillance began to follow Jacobson, Bobb, and Solof, seeking to identify their suppliers and customers. We also began amassing information about their bank accounts and other assets.

In May 1992, we commenced court-ordered electronic surveillance of Jacobson, Bobb, and Solof. From that electronic surveillance, we found that each had a number of suppliers, in addition to CW2, and each other. More important, each also regularly supplied his own roster of pharmacists with diverted drugs.

As the electronic surveillance continued, the number of targets tripled. The electronic surveillance intercepted a conversation in which Jacobson summed up the scheme: "Your tax dollars are paying for this merchandise," he said, explaining that the drugs he sold came from Medicaid recipients in Harlem who sold their "scrips." Jacobson added that not all of the drugs came from Medicaid recipients; some of them were salesmen's samples.

Beginning on June 30, 1992, the agents arrested, among others, 12 street-level diverters, 15 high-level diverters, and 38 pharmacists. In addition, they searched 34 pharmacies and 19 other locations, including the residences of various street level and high-level diverters, as well as rental storage units maintained by Jacobson and Bobb.

Under the authority of the search warrants, the agents seized virtually the pharmacies' entire inventories, into which the diverted drugs had been commingled and, from almost every search warrant location, stashes of diverted drugs.

At the same time, based on the money-laundering statutes, we initiated forfeiture proceedings against, among other things, the high-level diverters' and pharmacists' bank accounts, safe deposit boxes, and other assets, and against the bank accounts and leaseholds of 11 of the pharmacies.

The defendants were charged under a variety of legal statutes, and I will just refer to some of them: the "Tylenol Tampering Law," conspiring to violate the various laws against adulterating and misbranding prescription drugs, mail fraud, and wire fraud.

The forfeiture case relied on the contention that the high-level diverters' and pharmacists' activities constituted the laundering of the proceeds of mail and wire fraud. In order to forfeit the entire seized inventories of prescription drugs, we intended to institute civil un rem condemnation proceedings under title 21, on the untested grounds that, because it was impossible to tell which drugs in the pharmacy had been obtained from diverters and which had been obtained from legitimate sources, the pharmacies' entire inventories were adulterated and misbranded.

To date, 65 defendants in the Goldpill case, including CW1 and CW2, have pleaded guilty to felonies; 53 pleaded guilty as part of a collective plea arrangement under which those who had pharmacist licenses agreed to surrender them to the New York State Office of Professional Discipline. Those who had drugs seized agreed to forfeit them. Those who had bank accounts or other properties seized agreed to forfeitures of all or part of that property. In all, the defendants had agreed to the forfeiture of bank accounts, businesses, cash, and other property in excess of $3.5 million. That figure does not include any value for the seized drugs which, in our view, have no value, because they cannot be used.

All 11 pharmacies against which forfeiture proceedings had been initiated have been forfeited in whole or in part.

Most of the pharmacists and street-level diverters have received sentences of between 4 months and 12 months imprisonment, with fines ranging from zero to $40,000. Few of the high-level diverters have been sentenced, to date. Those who have been sentenced have received sentences as lenient as probation, with a $2,000 fine, and as severe as 30 months' imprisonment, and a $25,000 fine.

Mr. TOWNS. Ms. Neiman, let me indicate your entire statement will be included in the record, so if you could just briefly, you know, just finish up so the members will have an opportunity to raise questions.

Ms. NEIMAN. I will, Your Honor.

The Khan case, as Your Honors know from the statement, came at the same problem from the end of the clinics, and the Khan case

focused on several clinics which were run by Mohammed Khan, where he put together patients who wanted to buy scrips with doctors who were willing to cheat the Medicaid system and lend their provider numbers to the clinics for the billing of wholesale tests and to distribute prescriptions and a lab, which was willing to bilk Medicaid, as well as a pharmacy which was owned and operated by Khan and his associates.

And, if I might, let me just describe a typical day at the clinic, very similar to what Congressman Rangel described he saw when he would walk around in his congressional district.

Homeless people, drug addicts, and others down on their luck used to gather in front of the Khan Clinics early every morning. They would wait, sometimes for hours, until the clinic opened. A member of the clinic would gather their Medicaid cards, and the first 30 to 40 people in line were the people who the clinic would see that morning.

The people came not to get medical attention. They came for one reason: to get prescriptions for expensive brandname drugs that they could resell on the street for cash, and they didn't have to go very far. They would get the prescription, fill it at the pharmacy next door, and right outside the door, there would be a street-level diverter willing to buy the prescription from them.

The "patients" called this "playing the docs."

Very often, in addition to giving blood tests, the patients underwent unnecessary procedures. However, in many instances, those procedures, although billed, were never really performed.

Only two of the medical doctors at the Khan Clinic ever showed up at the clinics at all, and then one of them, only on Saturdays, and another one who came, after a few weeks decided there was no point. He could make the same money by not showing up, and so he didn't show up. And, apparently, under New York law and even under Medicaid, a doctor does not have to be at the clinic and can be miles away or, in this case, once, on vacation, while a physician's assistant simply routes the people through the clinic and dispenses the drugs and the tests.

The Khan case was just concluded, with the successful conviction of four doctors. All of the rest of the individuals, except for one fugitive in the Khan case, entered guilty pleas. The doctors were convicted of racketeering, racketeering conspiracy, mail fraud charges, and money-laundering charges.

In total, in the Khan case, 21 people were convicted of felonies.

The records maintained by the Department of Social Services show that the Khan Clinics bilked Medicaid out of $8 million in the roughly 1 year in which those clinics operated.

If I might conclude, the Goldpill case and the Khan case illustrate how unscrupulous individuals can take advantage of the principle that stealing a little many times over adds up. In our view and, apparently, in the view of this committee, the most significant people in these schemes are the medical professionals, upon whom the Medicaid program necessarily relies, to determine what medical services patients actually need. Medical professionals tempted to cheat the system are also, we believe, the most easily deterred by the fear of criminal prosecution, which can not only result in in-

carceration, but also the loss of their licenses, livelihoods, and status in the community.

Such professionals should be put on notice that there will be certain detection and punishment for participating in these schemes. Without their complicity, fraud schemes like the ones I've described will be much more difficult to perpetrate.

I'll be glad to answer any questions.

Mr. TOWNS. Thank you, very much. And, as I indicated, your entire statement will be included in the record.

[The prepared statement of Ms. Neiman follows:]

Department of Justice

STATEMENT OF

SHIRAH NEIMAN
DEPUTY UNITED STATES ATTORNEY
SOUTHERN DISTRICT OF NEW YORK

BEFORE THE

SUBCOMMITTEE ON HUMAN RESOURCES AND
INTERGOVERNMENTAL RELATIONS
COMMITTEE ON GOVERNMENT OPERATIONS
U.S. HOUSE OF REPRESENTATIVES

CONCERNING

MEDICAID FRAUD

PRESENTED ON

AUGUST 2, 1993

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today to talk about what we at the U.S. Attorney's Office have learned while investigating and prosecuting prescription drug diversion in the Southern District of New York.

I. Background

Our Office has recently concluded two significant prosecutions of prescription drug diverters. The first of these prosecutions, a group of cases known collectively as "the Goldpill case," traced diverted non-controlled prescription drugs from Medicaid recipients through several levels of illicit distribution and ultimately to the unsuspecting consumer. The second case, United States v. Mohammed Sohail Khan, et al., focused on a chain of clinics that paid Medicaid recipient "patients" for their participation in a large-scale fraud on Medicaid, by providing them with bogus prescriptions.

In the scheme that was the focus of the Goldpill and Khan cases, Medicaid recipients obtained prescriptions for drugs -- usually particularly expensive drugs -- that they did not intend themselves to take and filled them at pharmacies at taxpayer expense. The Medicaid recipients then illicitly sold these drugs to "street-level diverters," also known as "non men." Ordinarily,

the street-level diverters sold the drugs to "high-level diverters," who in turn sold them to other high-level diverters or directly to pharmacies. Pharmacists at the purchasing pharmacies, who bought the drugs at a discount from the price they would have had to pay legitimate suppliers, then dispensed the diverted drugs to the public.

The Medicaid recipients and drug diverters frequently removed the drugs from the original bottles in which they had been dispensed, and repackaged them in plastic bags and other containers. In other instances, diverters, using counterfeit labels and safety seals, repackaged drugs. As a result, consumers were put in jeopardy of receiving unsafe drugs, because the diverted drugs were frequently dispensed to consumers without the benefit of accurate information about the drugs. In particular, these drugs often lacked accurate expiration dates, which are necessary to monitor a drug's potency, and lot numbers, which are necessary in case of a manufacturer's recall. In addition, the diverted drugs were often stored by drug diverters under conditions that were unsanitary and that were not temperature controlled, thereby posing further risks to the consumers who ultimately were dispensed these drugs.

In the Goldpill case, physicians' samples were another source of prescription drugs. The samples, which are given to doctors and others for free to promote the sale of the drugs, were

illegally sold for profit. All marking and packaging indicating that the drugs had been designated as samples were removed. Where the word "sample" was stamped on individual pills, diverters went so far as to scrape it off, pill-by-pill. In the process, all labelling indicating the lot numbers and expiration dates were also removed. As with the drugs obtained from Medicaid recipients, the drugs were frequently stored under unsanitary and non-temperature controlled conditions, presenting risks to the consumer. Thereafter, the drugs were sold to pharmacists at a discount.

II. The Goldpill Case

A. The Investigation

The first real break in the Goldpill case came in the summer of 1991, with the arrest of a person who later became a cooperating witness ("C/W-1"). Based on a tip from a confidential informant, Federal Bureau of Investigation ("FBI") agents and Food and Drug Administration ("FDA") investigators ("the agents") surveilled a Bronx health and beauty aid store owned by C/W-1. They watched numerous individuals deliver boxes and bags to the store. The agents could see that some of the bags and boxes contained pill bottles and other medication containers. Some of the individuals could be seen counting money as they left the store.

Based on the surveillance and on the information supplied

by the confidential informant, we obtained search warrants for the store and for C/W-1's residence. The agents found approximately $500,000 cash in C/W-1's residence. C/W-1, under questioning, admitted that he had a stash house for diverted drugs in the Bronx and allowed the agents to search it. There, the agents found a collection of diverted drugs, later valued at approximately $1,000,000. Most of the drugs were loose in open plastic tubs. Nearby were thousands of prescription labels that appeared to have been removed from prescription bottles, scraping tools, a pill counter, counterfeit manufacturers' labels and counterfeit safety seals.

In the face of this evidence, C/W-1 immediately agreed to cooperate. He admitted that he had been in the drug diversion business for approximately four years. During that time, he had built up a roster of approximately a dozen individuals, whom we termed "street-level diverters," who supplied him with drugs that they in turn had bought on the street from Medicaid recipients. C/W-1 bought the drugs loose, in prescription vials, in counterfeit packaging, and in original manufacturers' packaging. C/W-1 thereafter sold the drugs, primarily to a high-level diverter who was an important target, because it was he who could lead us to pharmacists and other high-level diverters. Since he ultimately did become a cooperating witness, I will refer to him as "C/W-2."

The investigation then focused on building cases on the

street-level diverters who supplied C/W-1, and on C/W-2. It was relatively simple to gather evidence on the street-level diverters. C/W-1, accompanied by an FDA investigator working undercover, just continued buying diverted drugs from the street-level diverters.

Gathering evidence on C/W-2 posed more difficult problems. Obviously, C/W-1 could not continue to pass on to C/W-2 the potentially unsafe drugs that had been obtained from the street-level diverters. However, we had to corroborate C/W-1's statement that he had been providing diverted drugs to C/W-2. Therefore, with FDA approval, we decided to have C/W-1 sell apparently diverted drugs to C/W-2 -- in other words, to borrow the parlance of narcotics law enforcement, to have C/W-1 make "reverse sales" to C/W-2. The agents obtained drugs from manufacturers and legitimate wholesalers. Under the supervision of a pharmacist who was also an FBI agent, they altered the packaging of the drugs so as to give the drugs the appearance of having been diverted. These alterations included removing outer boxes and package inserts, breaking safety seals, and removing part of the manufacturers' labels. Occasionally, to maintain his believability with C/W-2, C/W-1 also sold loose prescription drugs, under the agents' supervision. In all instances, to minimize any danger to consumers, only those drugs with relatively distant expiration dates and stable compositions were selected, and their lot numbers were recorded and filed with the FDA.

It was not clear that accepting drugs that the agents had obtained and prepared in this manner violated any significant criminal law. Thus, we determined that the sales of drugs under the supervision of the agents would be used as corroboration of the illegal conspiracy that had existed before C/W-1 became a cooperating witness, not as evidence of further crimes.

In January 1992, having gathered sufficient evidence, the agents arrested C/W-2 and searched a rental storage locker he maintained on Long Island. C/W-2's storage locker -- which lacked ventilation and temperature controls -- contained a large inventory of diverted drugs. C/W-2, like C/W-1, immediately agreed to cooperate. He told the agents that, for approximately five years, he had been in the business of buying and selling diverted drugs. He sold the drugs he obtained from C/W-1 to five pharmacies and to three other high-level diverters -- Stanley Jacobson, Martin Bobb, and Donald Solof, who also supplied C/W-2 with diverted drugs.

Under the agents' supervision, C/W-2 began making a series of reverse sales -- selling to Jacobson, Bobb, Solof and his pharmacist customers, drugs that the agents had obtained and disguised so that they appeared to have been diverted. In the meantime, an FBI surveillance team began to follow Jacobson, Bobb and Solof, seeking to identify their suppliers and customers. We also began amassing information about Jacobson's, Bobb's and Solof's bank accounts and other assets.

In May 1992, based on a judicial finding that evidence of the scheme would constitute evidence of mail fraud and of tampering with consumer products, we commenced court-ordered electronic surveillance of Jacobson, Bobb and Solof. From that electronic surveillance, we found that Jacobson, Bobb and Solof each had a number of suppliers in addition to C/W-2 and each other. More important, each also regularly supplied his own roster of pharmacists with diverted drugs. As the electronic surveillance continued, the number of subjects of our investigation quickly tripled.

The electronic surveillance intercepted a conversation in which Jacobson summed up the scheme: "Your tax dollars are paying for this merchandise," he said, explaining that the drugs he sold came from Medicaid recipients in Harlem who sold their "scrips." Jacobson added that not all of the drugs came from Medicaid recipients; some of the drugs were salesmen's samples.

We also learned that one of Jacobson's, Bobb's and Solof's biggest problems was managing the large amounts of cash that their illegal business produced. Jacobson, Solof and Bobb had no-show jobs with businesses that Jacobson had set up, so as to be able to report some legitimate income. Solof and Bobb paid Jacobson cash and Jacobson, through one of the businesses, issued phony "paychecks." Jacobson and Bobb also maintained safe deposit boxes into which they put monies that they were not able to

integrate into their legitimate-appearing bank accounts.

At one point during the electronic surveillance, convinced that having large bills would incriminate them, Jacobson and Bobb discussed converting their cash into smaller denominations. That, however, presented storage problems. When Jacobson pointed out to Bobb that he had a large safe deposit box, Bobb remarked that that would not be sufficient -- that the bills would take up so much space "you're going to have to have a mausoleum."

Beginning on June 30, 1992, the agents arrested, among others, twelve street-level diverters, fifteen high-level diverters, and thirty-eight pharmacists. In addition, they searched thirty-four pharmacies and nineteen other locations, including the residences of various street-level and high-level diverters and rental storage units maintained by Jacobson and Bobb.

Under the authority of the search warrants, the agents seized virtually the pharmacies' entire inventories, into which the diverted drugs had been commingled, and, from almost every search warrant location, stashes of diverted drugs.

At the same time, based on the money laundering statutes, we initiated forfeiture proceedings against, among other things, the high-level diverters' and pharmacists' bank accounts, safe

deposit boxes and other assets, and against the bank accounts and leaseholds of eleven pharmacies.

B. The Prosecution

The defendants were charged under a variety of legal statutes:

First, many of the defendants were charged with conspiring to tamper or attempt to tamper with consumer products. See 18 U.S.C. § 1365(e). This law, commonly known as the "Tylenol tampering law," requires a showing that defendants acted "with reckless disregard for the risk that another person will be placed in danger of death or bodily injury and under circumstances manifesting extreme indifference to such risk."

Second, the defendants were charged with conspiring to violate the various laws against adulterating and misbranding of prescription drugs, under Title 21. See 21 U.S.C. §§ 331(b), 331(c), 331(k) and 333(a)(2). To prove a felony violation of these laws, the Government is required to show that the defendants acted with intent "to mislead and defraud." See 21 U.S.C. § 333(a)(2).

Third, many of the defendants were charged with conspiring to sell, purchase, and trade prescription drug samples, in violation of the Prescription Drug Marketing Act, Congress' previous effort to stem the diversion of prescription drug samples. See 21 U.S.C. §§ 331(t), 331(b)(1) and 353(c)(1).

Fourth, many of the defendants were charged with conspiring to violate the laws against mail and wire fraud on prescription drug consumers for selling them diverted drugs, on the ground that, for the fraud scheme to work, the pharmacists had to use the mails and interstate wires to obtain reimbursement from third-party providers. See 18 U.S.C. §§ 1341 and 1343

Fifth, many of the defendants were charged with conspiring to make false statements and representations of material fact in applications for benefits under Medicaid, because that the Medicaid recipients involved in the scheme impliedly represented that they would themselves be taking the drugs rather than reselling them. See 42 U.S.C. § 1320a-7b(a)(1).

The forfeiture case relied on the contention that the high-level diverters' and pharmacists' activities constituted the laundering of the proceeds of mail and wire frauds. In order to forfeit the entire seized inventories of prescription drugs, we intended to institute civil in rem condemnation proceedings under Title 21, on the untested ground that, because it was impossible to tell which drugs in the pharmacy had been obtained from diverters and which had been obtained from legitimate sources, the pharmacies' entire inventories were adulterated and misbranded. See 21 U.S.C. § 334(a).

C. Outcome

Only four defendants -- all street-level diverters -- have gone to trial. Of these, two were convicted at trial of felonies and two were convicted of misdemeanors. A Government appeal of a later judicial decision to reduce one of the felony convictions to a misdemeanor is pending.

To date, sixty-five defendants -- including C/W-1 and C/W-2 -- have pleaded guilty to felonies. Fifty-three of the defendants pleaded guilty as part of a collective plea arrangement. Under the plea agreements, those who had pharmacist licenses agreed to surrender them to the New York State Office of Professional Discipline; those who had had drugs seized, agreed to forfeit them; those who had had bank accounts or other property seized agreed to forfeitures of all or a part of that property. In all, the defendants -- including C/W-1 and C/W-2 -- have agreed to the forfeiture of bank accounts, businesses, cash and other property in excess of $3.5 million. All eleven pharmacies against which forfeiture proceedings had been initiated have been forfeited, in whole or in part.

Most of the pharmacists and street-level diverters have received sentences of between four months and twelve months imprisonment, with fines ranging from zero to $40,000. Few of the high-level diverters have been sentenced to date. Those who have

been sentenced have received sentences as lenient as probation with a $2,000 fine and as severe as thirty months' imprisonment and a $25,000 fine.

III. United States v. Mohammed Sohail Khan, et al.

A. The Investigation

The Khan case centered on four sham medical clinics located in the Bronx and Manhattan. The clinics, which were owned and operated by defendant Mohammed Sohail Khan and his associates, operated from early 1990 through July 1991. The investigation also focused on a pharmacy, which was adjacent to one of the clinics and was also owned by Khan and his associates, and a medical laboratory that billed Medicaid for tests ordered by doctors and physicians' assistants working in the Khan clinics.

The investigation revealed that "patients," who had no legitimate medical need for prescription drugs, were induced to come to the Khan clinics to obtain prescriptions for non-controlled prescription drugs. The "patients" received the prescriptions as payment for giving blood samples and lending their Medicaid recipient numbers to a scheme masterminded by Khan and his associates. The "patients" used the prescriptions to obtain drugs for free through the Medicaid program from pharmacies, including the pharmacy adjacent to one of the clinics, and then resold the drugs to street-level diverters. The practice was so common among

the "patients" at the Khan clinics that it was known as "playing the docs."

A typical day at a clinic began early each morning before sunrise when homeless people, drug addicts and others down on their luck slowly gathered outside. There they would wait, huddled together on the sidewalk, sometimes for hours, until a Khan employee came to open the metal gate to the storefront clinic to start the day. These indigent people had not gathered to receive real medical attention. They came for one reason: to get prescriptions for expensive brand name drugs that they could resell on the street for cash. The rules of the game were simple: you give the clinic a valid Medicaid card and a blood sample. In exchange, they give you a prescription -- a "scrip" -- for four or five expensive drugs that could easily be resold to a street-level diverter who hung out in front of the neighborhood pharmacy. Each morning the metal gate would open at the clinic and the security guard or receptionist collected the Medicaid card from those who considered themselves to be lucky enough to be among the first 30-40 "patients."

The "patients" provided the clinics with valid Medicaid recipient numbers and submitted to thousands of unnecessary medical tests and procedures so that the clinics could, with the collusion of doctors and a laboratory involved in the scheme, bill Medicaid. These tests included expensive blood tests, pulmonary function

tests, electrocardiograms, sonograms, and hearing tests. Some of the tests were not administered, but just billed.

The primary role of the medical doctors was to provide the enterprise with valid New York State Medical licenses and New York State Medicaid Provider numbers to be used to issue prescriptions and bill Medicaid. Only two of the six medical doctors charged in the scheme actually met with patients at the clinic. One met with patients only briefly on Saturdays, even though the clinics billed under her Medicaid provider number for "patient" visits and tests throughout the week. The other doctor met with "patients" for only a few weeks before he stopped coming to the clinics, having realized he could make just as much money without actually seeing any "patients." The physician's assistants, without the doctors' supervision, met with "patients," ordered tests, filled out "patient" charts, and wrote prescriptions, using the Medicaid provider numbers supplied by the absent doctors.

Since only medical providers such as doctors, laboratories, and pharmacies could bill Medicaid directly, the Khan clinics matched up Medicaid recipients willing to lend their Medicaid recipient numbers to the fraud in exchange for prescriptions and doctors and a laboratory prepared to use their Medicaid provider numbers to bilk Medicaid. For performing this function, the clinics received kickbacks from the doctors

(disguised as rent payments) and from the laboratory. Since Khan and his associates owned the pharmacy adjacent to one of the clinics, they were also able to bill Medicaid directly for the prescriptions that the "patients" filled there.

As the New York State Department of Social Services ("DSS") -- prompted by noticeably large billings that showed up in its periodic computer runs -- opened investigations of doctors associated with the clinics, the clinics would recruit new doctors, frustrating efforts to detect the fraud. Frequently, signs were posted at the clinics saying that only "first-time patients" would be seen that day. A so-called "first-time patient" was one for whom Medicaid had not yet been billed for a visit with whichever doctor was purporting to service "patients" that day at the clinic. Thus, a repeat "patient" at the clinics could be a "first-time patient" each time that a "patient" saw a different doctor. "First-time patients" presented a significant advantage over repeat "patients." Medicaid could be billed for a comprehensive initial office visit, as well as a fresh battery of unnecessary tests.

The FBI learned about the scheme in late 1990, when an FBI agent investigating the illegal disposal of medical wastes began interviewing people who knew about the clinics. As the agent began to make inquiries, he learned from the New York Department of Social Services that "shoppers" -- actually employees of DSS acting in an undercover capacity -- had gone into the Khan clinics and had

confirmed the existence of the scheme. The FBI, in conjunction with investigators from the Internal Revenue Service and the U.S. Department of Health and Human Services, began to interview former employees of the clinics, most notably a former manager of one of the clinics and many of the clinics' former "patients."

In the spring and summer of 1991, a local news channel aired a series about the Khan clinics. At about the same time, Medicaid cancelled the Medicaid provider numbers used by the laboratory associated with the clinics. Khan and his associates closed down the clinics, rendering further undercover initiatives impossible.

In October 1991, however, the investigative team discovered that, at the sites of three of the four former clinics, Khan and his associates had left behind large portions of the clinics' records, including many of the "patient" charts. By analyzing the records and obtaining the cooperation of several of the clinics' former employees and former "patients," the case was pieced together.

B. The Prosecution

On November 19, 1992, an indictment was filed charging Mohammed Sohail Khan, two of his key associates, six medical doctors and two physicians' assistants. The indictment charged that the defendants had operated the clinics as a racketeering

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enterprise in violation of the laws against RICO and RICO conspiracy (18 U.S.C. § 1962), had committed numerous acts of mail fraud (18 U.S.C. § 1341), and had engaged in money laundering (18 U.S.C. § 1956).

C. Outcome

Before trial, six of the defendants entered guilty pleas, some pursuant to cooperation agreements, leaving four doctors for trial and one fugitive physicians' assistant. Khan himself pleaded guilty to RICO, two counts of mail fraud, and one count of money laundering, pursuant to a cooperation agreement.

At trial, all four doctors were convicted of racketeering, racketeering conspiracy, and mail fraud charges, and three of money laundering charges. In total, including those who pleaded guilty before the indictment was returned, 21 people -- including six doctors and seven physicians' assistants -- associated with the Khan clinics have pleaded guilty or been convicted at trial of felonies.

Based on a review of records maintained by the DSS, it is estimated that the fraud cost the Medicaid program approximately $8,000,000 in fraudulent billings during the roughly one year that the clinics operated. All of the defendants in the case are awaiting sentencing.

IV. Conclusion

To us, the Goldpill case and the Khan case illustrate how unscrupulous individuals can take advantage of the principle that stealing a little, many times over, adds up. In our view, the most significant people in these schemes are the medical professionals, upon whom the Medicaid program necessarily relies to determine what medical services patients actually need. Medical professionals tempted to cheat the system are, we believe, the most easily deterred by the fear of criminal prosecution, which can not only result in incarceration, but also the loss of their licenses, livelihoods and status in the community. Such professionals should be put on notice that there will be certain detection and punishment for participating in these schemes. Without their complicity, fraud schemes like the ones I have discussed with you today will become much more difficult to perpetrate. I will be glad to address any questions the Subcommittee may have.

Mr. TOWNS. Let me begin by—do you have written or informal guidelines to determine whether or not you will prosecute, based on the amount?

Ms. NEIMAN. I don't believe so. I think that we have been prosecuting cases that have been brought to us. The volume of cases is not that large that we have felt the need to set a floor and say we won't prosecute if the case involves "X" amount of loss or money.

So, basically, if there's enough evidence so that we can develop the case and prove criminal intent, we will go forward and try to make the case.

Mr. TOWNS. Let me ask this: What percent of the cases that are brought to you that you prosecute?

Ms. NEIMAN. On Medicaid fraud or——

Mr. TOWNS. Yes, Medicaid.

Ms. NEIMAN. I can't answer that, but if I had to guess I would say that we prosecute most of them. And, if there's anything that we decide not to prosecute, it's because we don't believe there's enough evidence and, for whatever reasons, the agency agrees that more evidence can't be developed.

But, it may even be that 100 percent of the cases are prosecuted. I can't—I can try to go back to the office and see that and look that up, but I think that the Khan and Goldpill cases, which were major cases involving very large numbers—over 80 together—in two cases of defendants, were the main cases that were worked on in our office in the last 2 years.

Mr. TOWNS. You are in the southern district?

Ms. NEIMAN. Southern district, correct.

Mr. TOWNS. How many prosecutors do you have assigned to Medicaid fraud?

Ms. NEIMAN. As many as we may need. This particular case was developed out of, by an assistant—the Goldpill case—who was assigned to the narcotics and dangerous drug unit, the senior unit in our office.

As the case developed and toward the end of the investigation, additional attorneys were assigned to the case. After the case was taken down and the arrests were made, some of the cases were distributed to yet additional attorneys in our office, in various units.

We don't have specific assistants assigned to handle Medicare, Medicaid fraud and abuse, but we do have assistants available in many units who do all kinds of prosecutions, including this prosecution.

Mr. TOWNS. You talked about the Goldpill case and you talked about the Khan case, what is the range of prison sentences and fines that are available, in these two cases, under the sentencing guidelines?

Ms. NEIMAN. The sentencing guidelines for mail and wire fraud, and in the Goldpill case in general, are geared to the amount of the fraud. The fraud table starts at a level six, and you go up from there, based on the amount of loss. There may be a dispute in a case like this, on what the amount of loss is, but as you know from my written presentation, we stipulated to a loss in the Goldpill case.

So that, with the pharmacists, with the loss of $40,000, which was really based on the period of the electronic surveillance, the pharmacists faced sentences of a range of 8 to 14 months. As I think I said, most of them received jail sentences. Many of them received jail sentences—because the sentencing guidelines allow you to split the sentence—of 4 months in jail, followed by 4 months home confinement, or other kind of community service.

But, with a 40,000 guideline level of loss of fraud, it was 8 to 14 months. As the level gets higher, for the loss, the fraud table goes up.

The high-level diverters were subject, therefore, to much higher jail sentences.

Mr. TOWNS. Just before I yield to Congressman Mica, I think that in the Khan case, the loss was $8 million?

Ms. NEIMAN. If you calculate everything billed by these clinics during the year of their operation, and the lab, and the pharmacy, if you add that all together $8 million.

Mr. TOWNS. I'm going to yield to Congressman Mica, but just before I do, I notice that, you know, some of them got probation.

You know, how is that possible?

Ms. NEIMAN. Well, in the instance of one pharmacist, for example, who should have gotten a sentence of between 8 to 14 months, the judge downwardly departed, on the ground that that particular pharmacist had three young children. The Government, obviously——

Mr. TOWNS. I'm sorry. I didn't hear that.

Ms. NEIMAN. On the grounds that that particular pharmacist had three young children. The Government, obviously, objected, but the departure was granted.

A partner of that pharmacist then came back, asking that he, too, be sentenced to a downward departure from the jail sentence that had been imposed——

Mr. TOWNS. Because he had four children?

Ms. NEIMAN [continuing]. Because he had family problems of some sort. The judge, I think, realizing the error of his ways, said, "No, I'm going to decline to do that, and perhaps I made a mistake in the other case, but that's unfortunate, and I did it."

With the street-level diverter who got probation, if I might consult with Susan Brune, who ran the Goldpill case and who is here today, she might be able to tell me how that happened.

Mr. TOWNS. You can take a seat at the table, Susan.

Ms. BRUNE. Thank you, very much.

Ms. NEIMAN. As I understand, from Ms. Brune, the amount of loss for one of the high-level diverters was small and, therefore, the judge was able to impose probation. That doesn't mean he had to. I think the range was probably zero to 6 months, and the judge chose to impose probation.

In the other cases of the pharmacists or where the fraud level is higher, the judges have to enunciate reasons for downwardly departing and if they can't enunciate reasons that are consistent with the guidelines, they must impose a sentence within the range.

Virtually everyone did receive jail time, Ms. Brune tells me.

Mr. TOWNS. Well, let me just say this, that, and I know you're not the judge, but, you know, just looking at it, on the face of it,

it seems that they were sort of weak, in terms of sentences, and that will not serve as a real deterrent.

However, as I indicated, I know that that's another area and another category, so we won't dwell on that any longer.

Congressman Mica.

Mr. MICA. As a deputy U.S. attorney, you're familiar with the manner in which these cases are developed.

Did you see any problems with existing Federal law or anything that's within our purview, as far as interagency problems, lack of—I notice you prosecuted these folks under a number of different statutes.

Is there something missing here that should be called to our attention?

Ms. NEIMAN. I understand that the Department of Justice needs to separately propose legislation, and I'm not exactly authorized to do that. But, I can say, from my own personal point of view, it would be a lot easier if there were crimes specifically governing this kind of conduct.

We had to be creative——

Mr. MICA. Pick and choose, everything from RICO-like, prescriptions——

Ms. NEIMAN. That's correct. And, with different statutes having their own unique problems—for example, charging the pharmacists with fraud on Medicaid.

Because the original patient went into the clinic to get a prescription under fraudulent pretenses and then Medicaid, of course, was billed for a prescription given to someone who didn't need the drugs.

The pharmacist would say, what do I know? I had nothing to do with that. I'm five levels removed from that. For all I know, these were all physicians' samples, for example.

We felt that we could prove otherwise, but clearly it would have been easier if there were statutes specifically making this kind of conduct a crime.

Mr. MICA. How about your resources? Financial and staffing resources?

Ms. NEIMAN. You know, we always want and need more resources, but we were able to very effectively handle these prosecutions——

Mr. MICA. And your situation now——

Ms. NEIMAN [continuing]. And the FBI, as well.

Mr. MICA [continuing]. Your situation now? Are there cases that are referred—are you, like Florida, they cited, well, their particular fraud unit was rejecting 90 percent, because of their inability to handle them.

What about at the prosecution——

Ms. NEIMAN. That's not happening. I think we are suffering from the 7 percent staff cut, but we're just forging ahead and working harder and staying later and we're handling the cases that we have. We don't have any cut in output.

Mr. MICA. Thank you, Mr. Chairman. I yield back.

Mr. TOWNS. Thank you, very much, Congressman Mica.

I yield to Congressman Schiff.

Mr. SCHIFF. Thank you, Mr. Chairman.

I just want to ask about one area, and I'm glad that the prosecutor of the case is here, too. Based on the question that I asked the previous witness, and that is: Of the defendants who were convicted in the Goldpill case, of those defendants who hold or held at the time, professional licenses—physicians, pharmacists, lawyers, if any, whatever—I wonder if you know what the result has been, regardless of whether they got jail time or didn't get jail time, what has been the result on the suspension or loss of their professional license?

Ms. NEIMAN. All of the pharmacists entered guilty pleas. We required, of each of them, as a condition of the guilty plea, that they surrender their licenses. They are no longer practicing pharmacists.

We did that because we felt that, after their conviction, that would be what would happen to them, and so we insisted, over great objection from the defense attorneys, but we insisted that as part of the global plea disposition, they surrender their licenses, which they did.

Mr. TOWNS. Will the gentleman yield?

Mr. SCHIFF. I yield to the chairman.

Mr. TOWNS. Yes, let me ask you, though, if the person is licensed in more than one State, what happens in a case like that?

Ms. NEIMAN. I don't know the answer. I don't think we believed that any of these pharmacists were, in fact, licensed in more than one State. I don't think we addressed that problem. Maybe we should have.

Mr. SCHIFF. If the chairman will yield back——

Mr. TOWNS. Yes.

Mr. SCHIFF [continuing]. I just want to go on that very question. That's what I was about to get at.

If the license is surrendered and it doesn't show anything more than the license surrendered in the official records of that particular regulatory board, then it seems to me that the individual involved might be free to reapply for its issuance in that State or, at the very least, go to another State, because there'll be nothing on the record except that he turned in his license.

Ms. NEIMAN. No, the Office of Professional Discipline in New York participated with us in the way in which the licenses were surrendered. Each one of them was then barred from having a license. They were each fined a set amount of money, and under the rules, I understand that they can reapply, but in practical effect, because of the amount of time that it takes to reapply, it would be 3 years before any of them could possibly be relicensed again in the State of New York.

Mr. SCHIFF. You stressed the State of New York. I'm just concerned that if they surrendered—if someone moved out of the State, he'd surrender the license. Surrendering the license does not indicate any misfeasance, by itself.

Ms. NEIMAN. Well, if their criminal record is checked by the other State's licensing authority, it would be disclosed that they were convicted and, hopefully——

Mr. SCHIFF. Well, it's obvious you don't look at it, look in the loop hole to let these people practice the profession again, and I don't think they should be practicing.

Do you have anything to add on that?

Ms. NEIMAN. No, except in response to Congressman Towns' comment that the penalties were not that harsh. I think that if you take into account that many of the pharmacists received jail terms of 4 months or more, that they were required to surrender their licenses, that as far as we know, they are not operating pharmacies and working in pharmacies in New York, and that many of them surrendered substantial amounts of money in bank accounts, and that some of them actually had to forfeit the pharmacies, in total—the Government attached the leaseholds and sold them and kept the money—that the penalties were fair and appropriate.

Mr. SCHIFF. I yield back to the chairman. Thank you.

Mr. TOWNS. Thank you, very much, and let me just say that, as I sort of look at this, I was just thinking, especially in this area, that a person could just go right over to New Jersey, or it's quite possible that people are licensed in more than one State. It happens all the time. And even practicing law, that you're licensed in more than one State.

And that, if it happens to you in New York, you wouldn't even have to move. Just commute right across the bridge, to New Jersey.

So, I think that there is some loop holes there that must be plugged, in order to be able to deal with the problem and deal with it effectively.

And also, I don't want to take too—to make an issue with you, but the point is that when you talk about millions of dollars and you're fined $40,000, that's not a whole lot. You know, we're talking about millions of dollars here, so I'm not going to argue that point with you, but I have a little different view of it, you know, in terms of the fact that I don't think it was really that harsh.

So, and I generally come down on the other side of the issue.

Ms. NEIMAN. I agree with you, in some respects, but you do have to look at each individual and see what that person was responsible for and, under the criminal justice system, that is the way the law is set up, and so it makes it a little more complicated.

Mr. TOWNS. Right.

Let me thank both of you, for your testimony, and appreciate your being very, very helpful and very informative.

Thank you, so much.

Ms. NEIMAN. Thank you.

Mr. TOWNS. Our final witness today, or witnesses, I should say, today, are Thomas Staffa and Beth Taylor.

Mr. Staffa is the chief of the criminal division in the Office of the Special Prosecutor for Medicaid Fraud Control, and Ms. Taylor is the director of the Texas Medicaid Fraud Control Unit in the Office of the Attorney General in Texas.

Will you please come forward?

It is the custom of this committee to swear their witnesses in.

[Witnesses sworn.]

Mr. TOWNS. Take your seats.

I would like to welcome you both to the subcommittee. Your complete testimony, without objection, will be included in the record.

Mr. Staffa, we will begin with you. Please proceed to summarize your testimony in 5 minutes, which will allow the members of the committee to raise specific questions with you.

You may begin.

STATEMENT OF THOMAS F. STAFFA, CHIEF, CRIMINAL DIVISION, OFFICE OF THE NEW YORK STATE SPECIAL PROSECUTOR FOR MEDICAID FRAUD CONTROL

Mr. STAFFA. Good morning, and thanks for inviting my office to participate in these hearings. We are the State Medicaid fraud unit in New York, which is primarily responsible for prosecuting these cases in the State. Our office is comprised of approximately 300 individuals. We have 46 attorneys, about 100 investigators, and 100 auditors. We have, by far, the largest unit in the country.

We have seen in the past few years a frightful expansion of fraud in the area of drug diversion. Only 5 years ago, it was commonplace for us to see $50,000 to $100,000 cases. And now, it's becoming more and more common to see multimillion-dollar cases.

One thing I want to emphasize, with respect to drug diversion, and it's an important thing to be investigating, and it's an important thing to be conscious about, but it is only one part of the Medicaid fraud problem. In fact, all the drug diversion cases, as they showed themselves in the Goldpill case and as have showed themselves in all of our cases, are part of a conspiratorial type of problem with the system that involves not only the pharmacy, because it starts at a clinic.

It starts with the recipient getting this prescription, and from that point, the fuel is generated for frauds against other components of the system, including laboratory tests for blood samples that these recipients give; the pharmacy, of course, which leads to the drug diversion; but also sonograms, which are taken of every recipient who enters these ghetto clinics. And these sonograms go to a radiologist, who's also defrauding the system for having read a completely bogus sonogram.

So that in every case where there's drug diversion, it's only the starting point for other parts of fraud against the program, especially in New York City.

Just drug diversion alone, in the scams that you've heard about this morning, amount to between $75 million and $150 million being stolen from the State every year. The "playing doctor" scam was alluded to in the Goldpill presentation, and it basically involves a vast network of Medicaid physicians, pharmacists, and recipients engaged in the blatant stealing of drugs for scrips in exchange for cash on the black market.

As Congressman Rangel said, it's become almost an American Express Gold Card. People leave the house and say "don't leave home without" these particular Medicaid cards, because that's what it's become.

The term "narcotic drug" is not necessarily the main problem in the system any more. The recipients have gotten smart and realized, as have the providers, that there's a lot of danger in providing controlled substances in these scams, and that's why in the last few years there has evolved this problem with the noncontrolled drug, the so-called "glamour" drugs. Basically, the term "noncontrolled" is apt, because the perception on the street is that there is no control.

There is, in this particular situation, the recipients will line up at 5 a.m., outside of these clinics. Nobody is going there for medical care. Poor people in the cities will tell you that when they want to receive medical care, they don't go to these clinics. They go to the emergency rooms of the city hospitals. They're not dispensing care at these clinics. They're dispensing prescriptions.

Now, these noncontrolled drugs are easy to get. Once you get inside, the security guard or the receptionist will sometimes prompt you as to what magical words to say to the doctor in exchange for the type of drug you want to get. For example, for Zantac, you say "ulcers;" "allergies," Seldane; "depression," Prozac; "backache" means Feldene. So that the doctor has just enough medical justification to issue his fraudulent prescription.

Now, this ties into some of the difficulty in making these cases. The doctor is going to argue to you that "I made a cursory examination, and a Medicaid patient told me that he had a problem, so I prescribed a drug." So, it's very difficult to meet the criminal standard beyond a reasonable doubt in that situation.

We, for example, had raided an apartment in the Bronx, and we had many cases like this, but this is one example. Our investigators raided four Bronx apartments and arrested seven drug diverters, including both legal and illegal immigrants from the Dominican Republic and Mexico, for scheming to defraud the Medicaid program, and they were doing it by illegally buying and selling costly prescription drugs, such as Prozac, Zantac, and the AIDS medication, Retrovir, which is AZT. In the apartment, which was used for the defendants as a depot to warehouse their huge inventory of drugs, we found 200,000 pills, worth an estimated street value of $500,000. Each apartment was a virtual drug store, complete with drug repackaging paraphernalia, empty vials, blank pharmacy labels, and blank prescription forms. Many seized medications were still packaged in their original containers. And, amazingly, in one situation, it had taken only 3 days for a bottle of AZT, dispensed in Maine, to make its way to the black market in the Bronx.

I'll give you some sense about what the return is on this type of activity. A sealed bottle of 100 AZT tablets, for which Medicaid would reimburse a dispensing pharmacy $190, was illegally sold in Manhattan for $45 and for $65 in the Bronx. The cost of 100 loose AZT pills was discounted to $35. For an extra $4, you can get an empty AZT bottle, and for $10 more, they will reseal the bottle for you.

If any of these drugs should find their way to Puerto Rico, and many do, a bottle of those would carry a, between a $600 to $700 price tag, because it's difficult to get AZT in Puerto Rico.

Not all of this is gloom and doom. Recently, we have seen quarterly Medicaid expenditures for certain traditionally prescribed drugs dropping from $37 million in 1990 to under $17 million in 1991. Likewise, in New York, because we've gone to triplicate prescriptions for controlled substances, certain of the abused drugs like Valium, Xanax, Halcion, and Ativan, have dropped by about 44 percent.

Some of the things that State prosecutors feel that are important and some of the things that we need to have some assistance in

this area is, inasmuch as it's in the physician's power to write scrips and demand kickbacks, we need tough felony kickback statutes in the State, as the Federal Government has. We do not have those. In New York State, for the same type of activity that goes on in case after case, where the drug diverters will exchange the drug, in exchange for cash, or the doctor in the clinic will give prescriptions in exchange for cash, those kickbacks in New York are only a misdemeanor, while they are Federal felonies.

In addition, to deal with the hemorrhaging caused by the "playing doctor" scam, we need State and Federal laws specifically prohibiting the sale, repurchase, and redistribution of Medicaid drugs. As the Federal prosecutor indicated before, you have to revert to mail fraud and some of those other statutes to deal with the problem, because there is not specifically a statute, either federally or locally, to deal with this particular drug diversion problem.

We also need, in New York, as is starting to happen now, performance bonds for some of the major providers, so that they're not as likely to abscond with the goods.

We need utilization thresholds, which are just starting to be put into place. And, I'll tell you, there are some big loopholes with those. It sounds good to say that a particular recipient should only get 15 prescriptions a year, and I'm just using that as an example. But, there was so much political pressure when the program was first put into effect, because State assemblymen and senators did not want to buy the concept of limiting medical services to poor people. The fact is that a lot of the excessive billings were because the system was being beaten.

Now that we have this utilization threshold, at this point, unfortunately, it's very easy to get a waiver. They're almost automatically given. So, a lot of lip service may be paid to the fact that there are these thresholds, but they're very easy to overcome.

We've had situations—the utilization thresholds were only put into effect when we were starting to see things like single Medicaid recipients getting $175,000 worth of AIDS drugs in a year, or $50,000 in blood tests being charged to one particular recipient, or for one particular recipient, being charged for sonograms as if they had a sonogram taken every day, at $90, for an entire year.

One of the things that Congressman Rangel mentioned, which answers any question you might have about what you can do for us, involves the Federal matching funds. Until recently rebuffed by Congress, the administration proposed to change the matching funds for the State Medicaid fraud units from a share of 75 to 25 percent, effectively asking the States to double their contribution.

Based on what I can see, and we're all in close communication with all the other State units, a lot of units would have to cease to exist if that proposal ever made it to the light of day again. So when we're talking about things that might be helpful, certainly maintaining the strengths of the units would be helpful. I mean, everybody has been clamoring for more strength in the fight against fraud in the health care area, but at the same time, it's incongruous to me that a recommendation could be made to cut funds from the oversight people.

And, basically, those are just some of the things that I wanted to touch base on and I'd be happy, later, to answer any of your questions.

[The prepared statement of Mr. Staffa follows:]

TESTIMONY OF

THOMAS F. STAFFA
CHIEF, CRIMINAL DIVISION

OFFICE
OF
EDWARD J. KURIANSKY
NEW YORK STATE SPECIAL PROSECUTOR
FOR MEDICAID FRAUD CONTROL

BEFORE

U.S. HOUSE OF REPRESENTATIVES
COMMITTEE ON GOVERNMENT OPERATIONS
SUBCOMMITTEE ON HUMAN RESOURCES AND
INTERGOVERNMENTAL RELATIONS

PUBLIC HEARING ROOM CHAMBER
CITY HALL
NEW YORK, NEW YORK

AUGUST 2, 1993

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Mr. Chairman, Members of the Committee:

I am Thomas F. Staffa, Chief of the Criminal Division in the Office of the New York State Special Prosecutor for Medicaid Fraud Control. I am very pleased to appear before you today on behalf of Special Prosecutor Edward J. Kuriansky to discuss the pernicious problem of Medicaid fraud and prescription drug diversion.

Drug diversion in the Medicaid Program is a problem that affects all Americans. It not only contributes to this nation's already monstrous narcotics problem by providing addicts with a taxpayer-funded means to obtain their drug of choice, but it annually robs our beleaguered Medicaid system of untold millions of sorely needed dollars. Moreover, the ultimate consumers of these diverted and recycled goods -- namely, an unsuspecting American public -- may well be taking medicines that have lost their potency, been improperly stored and handled, or even been subject to recall.

The quality-of-life and economic damages wrought by this scourge on the neighborhoods, schools, and businesses of our inner cities are a source of deep and abiding concern to my Office -- a concern, I know, shared equally, by this Committee.

Medicaid, of course, is the primary government health-care program for more than 30 million of America's poorest and oldest citizens. On a national level, Medicaid expenditures will total more than $140 billion this year. While most of these taxpayers dollars go directly toward providing needed medical care for the intended beneficiaries, a tremendous amount -- indeed, somewhere between 5 - 20% by most estimates -- is lost to fraud and abuse year after year as the Program continues to offer the kind of sizeable cash rewards that attract predatory, and extremely cunning, providers.

As the investigative agency primarily responsible for monitoring the $20 billion annually spent on Medicaid in New York State -- approximately 1/7th of the nation's total -- we have been witness to some of the largest and most sophisticated frauds ever committed against the Program. During the past decade, in particular, we have literally seen a feeding frenzy on the Medicaid Program, a period of unprecedented white-collar theft in which wave after wave of multimillion dollar fraud has swept through nursing homes and hospitals, to clinics and pharmacies, podiatry and durable medical equipment (DME), radiology and labs, and more recently, home health care. Each surge has brought its own special brand of profiteer in search of the next great loophole in the Medicaid system.

From the mid-1980s forward, however, a fundamental change began to take place in the operation of inner city Medicaid "mills" that has led to a frightful expansion of drug diversion and other illegal activity. I refer specifically to the rise of a new breed of Medicaid entrepreneurs who thrive on the multiple, often hidden ownership of clinics that constitute nothing more than barely furnished, utterly inadequate medical facilities and that are often incestuously associated with pharmacies suited to little else than rapidly dispensing shopping

bags full of medically unnecessary prescription drugs and other high-cost Medicaid supplies.

Moreover, these voracious providers are, increasingly, of foreign extraction with the ability, at the first sign of trouble, to return to their homeland enriched with thousands, even millions, of taxpayer dollars. They have learned, largely from prior publicity, that by insisting on cursory patient examinations, blood tests, and occasional x-rays, they can virtually shield themselves from prosecution for state drug violations. In addition, these sophisticated practitioners know that repeated medical testing under less than optimal conditions poses a health danger to undercover agents and may thereby discourage clandestine probes.

Furthermore, whereas only a few years ago Program thefts generally ranged in the area of $50,000 - $100,000, Medicaid frauds now frequently total a million dollars and more. These new businessmen -- unlike the nursing home czars of yesteryear -- are in business for the sole and exclusive purpose of exploiting the Medicaid Program and have no interest whatsoever in delivering real medical care to real Medicaid patients.

Perhaps our most pressing concern in New York today is a recent phenomenon known as "playing doctor" that involves a vast network of Medicaid physicians, pharmacists, and recipients engaged in the blatant dealing of drugs and 'scrips for cash on the black market. Unlike many of the earlier frauds, this one is as much driven by recipients and their desire for drugs as it is by corrupt providers. For these abusive recipients, a Medicaid card has become their American Express gold card -- and on the street they say, only half-jokingly, "Don't leave home without it."

In the past several years, the "playing doctor" scam has been plaguing ghetto communities throughout New York City and probably costing taxpayers somewhere between $75 - $150 million a year. In this illicit underground economy, recipients -- often drug addicts -- "burn" their card (which means quickly running up $20,000 - $30,000 in Medicaid charges) by visiting unscrupulous doctors and obtaining utterly unnecessary prescriptions for a laundry list of medications.

These physicians operate out of seedy storefront offices that resemble fortified prison cells, and they occasionally examine -- or rather question -- their so-called "patients" via telephone through windowed wall partitions. In some instances, the doctor's receptionist or security guard will even tell the 20 - 30 patients crowded in the waiting room what they should say is ailing them and what drugs the doctor is willing to write that particular day.

For example, for over 3 years, Dr. Giovanni Del Gizzo, an East Harlem physician,

operated an assembly-line medical practice, catering largely to substance abusers and billing Medicaid more than $1 million. On any given day he would "see" upwards of 100 patients, almost all of whom invariably got prescriptions for tranquilizers, mood elevators, and skin lotions. In another case, Dr. Rodrigo Doronio Agpaoa, a physician in the Bushwick and Bedford-Stuyvesant sections of Brooklyn, wrote Valium prescriptions -- for $1 a pill -- without any examination whatsoever. The patients just asked him for Valium and Dr. Agpaoa wrote the 'scrip. To add insult to injury, the good doctor would also bill Medicaid for a host of other services he had never even provided -- such as comprehensive office visits, hearing exams, and intra-dermal tuberculosis tests.

Or consider the case of Dr. Shahid Siddiqui, another Brooklyn physician, who was accused of systematically looting over $1.4 million of the $2.5 million he received from Medicaid for supposedly treating the city's poor at his Flatbush clinic during a 2-year period. Dr. Siddiqui's scheme ran the gamut from hiring "impostor" doctors and other unlicensed personnel to see patients and order useless sonograms and echocardiograms, to selling tranquilizer prescriptions for cash on demand, and then secreting hundreds of thousands of dollars in stolen funds overseas in Swiss bank accounts.

Doctors like these are, in reality, nothing more than drug dealers with prescription pads. Their medical license has no value other than the power it gives them to turn 'scrips into cash. Nonetheless, even when they are convicted, there is at least a 75% chance they will not go to prison, and a nearly 50% chance they will not lose their license to practice medicine. Of 48 physicians convicted of felony Medicaid fraud by my Office prior to July 1991, nearly one-half received brief suspensions or suspensions that were immediately stayed. Of the 12 doctors who were sentenced to jail, only 4 got a year or more and the other 8 got a few months or weekends.

While the abusive dispensing of controlled drugs has hardly ended with these prosecutions, recipients nowadays invariably request prescriptions for <u>non</u>controlled, high-cost, brand name medicines -- the so-called "glamour" drugs. The term "noncontrolled" is an especially apt description for these drugs because the perception on the street is that there is absolutely <u>no</u> control.

Drug diversion is seen as an enterprise with few risks and great rewards. For example, the corrupt physician realizes that by making even a minimal effort to elicit symptoms and examine the patient, he makes it almost impossible to prove intent to steal under the criminal law standard of "beyond a reasonable doubt"; the pharmacist, for his part, artfully argues that he is merely filling a legitimate prescription written by a properly qualified, licensed doctor;

the drug diverter, a parasite who feeds off but never actually bills the Medicaid Program himself, feels relatively safe from law enforcement by dealing in non-contraband, non-narcotic substances; and the dishonest recipient knows that even if he "burns" his card for $15,000 - $20,000 in unnecessary services, he will likely be subject only to a misdemeanor prosecution at most, and that, even if convicted, he will probably never be thrown out of the Medicaid Program. Thus, each of the players at the table gets his own generous slice of the Medicaid pie -- and at preciously little peril.

This is why scores of patients are willing to gather in long lines as early as 5 or 6 in the morning and wait hours for a momentary visit with the doctor and why patient after patient report identical symptoms. They know exactly what "buzz" words to utter -- e.g., ulcers for Zantac; allergies for Seldane; depression for Prozac; backache for Feldene -- so that the doctor has just enough medical justification to issue his fraudulent prescriptions.

Once the prized prescriptions are in hand, a nearly unstoppable criminal chain reaction has been set in motion. The recipient may choose to "bust" the 'scrip by selling it to an accommodating pharmacist -- such as Benson Chanowitz, owner of the Abi Gezunt Pharmacy in the Bushwick section of Brooklyn, who we indicted for stealing over $173,000 from Medicaid by fraudulently billing for 1000's of expensive drug prescriptions he had actually bought for cash and never dispensed to patients.

In the more typical case, however, a recipient will actually have his prescription filled and sell the drugs for cash to so-called "nonmen" -- i.e., the buyers of noncontrolled substances -- who lurk nearby in the street outside the clinics and pharmacies. The patient will generally net 5% - 10% of the drugs' retail cost and thus get the pocket money -- usually $10 - $20 -- he needs to buy crack, alcohol, or other substance of his choice.

The "nonmen" and their "runners" then bring their wares to other, larger-scale collectors and diverters, who in turn resell the drugs to local pharmacies and discount stores, or sometimes even distribute them out of state or country to Caribbean-basin areas such as Puerto Rico, the Dominican Republic, and Colombia.

In 1992, for example, our investigators raided 4 Bronx apartments and arrested 7 drug diverters, including both legal and illegal aliens from the Dominican Republic and Mexico, for scheming to defraud the Medicaid Program by illegally buying and selling costly prescription drugs -- such as Prozac, Zantac, and the AIDS medication Retrovir (AZT) -- originally dispensed to Medicaid recipients. The apartments, located in the Tremont, Morris Heights, and Bedford Park sections of the Bronx, were used by the defendants as depots to warehouse

their huge inventory of drugs pending resale for cash to pharmacies and other diverters at greatly discounted prices. We seized over 200,000 pills (with an estimated wholesale value of more than $500,000) and $8,000 in cash.

Each apartment was a virtual drugstore, complete with such drug repackaging paraphernalia as empty drug vials, blank pharmacy labels, prescription forms, and resealing machines. Plastic bags containing 1000's of loose prescription drugs were found in closets, suitcases, and stuffed in dresser drawers. Many of the seized medications, still packaged in their original containers, had originally been dispensed to Medicaid recipients by pharmacies in New Jersey, Connecticut, Massachusetts, and Maine. Amazingly, it took less than 3 days for a bottle of AZT dispensed in Maine to make its way onto the black market in the Bronx.

The defendants repackaged, resealed, and resold the drugs to pharmacies and other drug diverters, charging approximately 35% of the average wholesale price. For example, a sealed bottle of 100 AZT pills, for which Medicaid would reimburse a dispensing pharmacy $190, was illegally sold for $45 in Manhattan and $65 in the Bronx. The cost of 100 loose AZT pills was discounted to $35. For an extra $4, they would provide an empty AZT bottle, and for $10 more, they would reseal the bottle. And should one of these AZT bottles eventually make its way to Puerto Rico, where the AIDS drug is hard to find, it might well carry a $600 - $700 price tag.

Though the thriving prescription drug market on our city streets has hardly abated, community complaints have lessened somewhat recently, and there have been a few other encouraging signs. For example, quarterly Medicaid expenditures for certain traditionally abused prescription drugs dropped from nearly $37 million in 1990 to under $17 million in 1991. Likewise, since New York State went to triplicate prescriptions for certain tranquilizers like Valium, Xanax, Halcion, and Ativan in 1989, the prescribing of these drugs fell by 44% overall and, among Medicaid patients, by over 60% -- with corresponding Medicaid cost savings of $27 million in the first two years.

In addition, we have also seen of late some vigorous interagency law enforcement cooperation in the drug diversion battle, as evidenced by the FBI's "Goldpill" operation last summer in which scores of investigators from our Office and other state agencies assisted federal agents in the execution of approximately 140 arrest, search, and forfeiture warrants throughout the New York-metropolitan area.

I must emphasize, however, that the ongoing spectacle -- in and around ghetto clinics and pharmacies -- of long lines of drug abusers, who seek not to obtain legitimate medical

care but rather to sell their Medicaid cards or medications for cash, cannot be adequately addressed by criminal investigation and prosecution alone. This is certainly not to say that our arrest of over 2000 corrupt Medicaid providers and vendors in New York in the past 15 years has not had a substantial and beneficial deterrent impact. In fact, our continuing statewide investigation of physicians and pharmacists, in particular, has resulted in criminal charges against 728 defendants, nearly $30 million in fines and restitution, and literally hundreds of millions of dollars in Medicaid savings. Nor is it to say that as long as Medicaid remains a fee-for-service program that gives patients freedom of medical choice and depends largely on provider honesty, state prosecutors and administrators nationwide will not require a vast array of additional enforcement tools:

For example:

- Inasmuch as it is the physician's power to write 'scrips and demand kickbacks from other providers that fuels so many of the more flagrant Medicaid abuses, we need the same tough felony kickback statutes and realistic immunity and accomplice corroboration rules that already exist under federal law;

- To deal with the current hemorrhaging caused by the "playing doctor" scam, we need new state and federal felony laws specifically prohibiting the resale, repurchase, and redistribution of Medicaid drugs and supplies, as well as a mandatory recipient photo I.D. program to help curb the rampant sale, rental, and theft of Medicaid cards;

- We also need to require -- as New York now does in certain cases -- performance bonds or other financial security from all high-volume providers so as to discourage hit-and-run assaults on the Program by those who, once caught, might be tempted to abscond the jurisdiction or secrete their assets abroad; and

- We need utilization thresholds -- also now being implemented in New York -- to restrict the number of doctor visits, prescriptions, lab tests, and DME supplies a recipient can receive without prior state authorization. It is simply intolerable that Medicaid could -- as has happened in New York in recent years -- be billed in the name of a single Medicaid recipient in a single year for $170,000 worth of AIDS medication or $50,000 in blood tests, or for a $90 sonogram each and every day of the year.

But clearly, a genuine solution to this Medicaid fraud - drug diversion epidemic will require a persistent and broad-based response by all federal, state and local bodies that oversee the Medicaid Program, and it would be dangerously naive to think that any of the

players in this low-risk, high-yield, drug-driven game will fold their cards and go quietly into the night anytime soon.

And finally, adequate federal and state funding for this nation's 41 Medicaid Fraud Control Units ("MFCUs") must be maintained. Unfortunately, the Administration, until just recently rebuffed by Congress, has been urging an ill-conceived proposal to reduce the Units' federal matching rate from 75% to 50%.

Medicaid Fraud Control Units, such as the New York Special Prosecutor's Office, are federally funded, state-run law enforcement entities which investigate and prosecute provider fraud and misconduct in the administration of the Medicaid Program. In addition, and perhaps even more important, the Units aggressively pursue complaints of patient abuse and neglect of the elderly in nursing homes and other Medicaid - funded health care facilities. The Units, which operate totally separate and apart from the single state administrative agency and are usually located in the state Attorney General's office, are staffed by professional teams of attorneys, investigators, and auditors specially trained in the complex litigation of health care fraud.

Under current legislation, the Units are funded on a 75% federal - 25% state yearly grant basis. The federal match is carried as part of the Medicaid Program's administrative costs within the budget of the Health Care Financing Administration ("HCFA"), with the Units' funds subsequently transferred to the Health and Human Services Office of Inspector General ("OIG") for distribution to the states.

In a cogent analysis of the recently proposed matching rate reduction, the Congressional Budget Office asked (1) whether the states still required "special incentives" for anti-fraud activities and (2) whether, if denied an enhanced match, the states might make "less effort" to eliminate Medicaid waste and abuse. Sadly, the answer to both questions is an unequivocal yes.

In practical terms, the Administration's proposal would have required a state to double its contribution from 25% to 50% just to maintain its Medicaid Fraud Control Unit at present strength. Coming at a time when cash-poor states are already unable to fully fund their Units -- let alone many other essential state programs -- this proposal would have surely resulted in most Units either being dissolved or drastically downsized. The fraud units are people-driven, not computer-driven entities, and the states' likely response to diminished federal funding would simply be to cut personnel. Right here in New York, for example, although annual Medicaid costs have mushroomed from $3 billion to over $18 billion during the past

15 years, state budgetary constraints have forced the Special Prosecutor's staffing level down by more than 33% since our original designation as New York's Medicaid Fraud Control Unit in 1978.

As far back as 1980, the General Accounting Office (GAO) studied this very issue and, while finding the Units to be an "effective force" in combatting Medicaid fraud, concluded that without continued 75% federal funding "many fraud units will probably cease to exist or operate at a reduced level of effectiveness." Indeed, even with the enticement of a 75% - 25% formula, most states have for many years chosen to operate their units at a funding level far below the maximum allowable federal reimbursement cap of 1/4 of 1% of a state's annual Medicaid expenditures. As a result, the federal government is today barely contributing $50 million a year -- or 1/28 of 1% -- to safeguard a program that is expected to cost over $140 billion this calendar year.

In sum, the Administration's proposal, which would have saved at best $15-18 million federal dollars per year (based upon a projected $72 million total federal/state program), would wind up costing taxpayers -- not to mention the fiscal and moral integrity of the Medicaid Program -- far more than it could ever save. The net effect would be a dramatic reduction in convictions, recoveries, and long-term deterrence, and substantially less emphasis on protecting the institutionalized elderly. Not only would this deal a crippling blow to the states' fight against fraud and abuse in the delivery of health care services, but would be particularly foolhardy in view of OIG's announcement earlier this year that it was ceasing federal Medicaid fraud investigations almost entirely and turning all new cases over to the Units.

Finally, I must reflect briefly on the prior history and current context of the recent proposal. The identical recommendation was first made by the Reagan Administration in the mid-80s and then again by the Bush Administration. The National Association of Attorneys General formally opposed any such reduction in the federal matching grant and urged Congress to reject it -- which Congress did on both occasions. In fact, at one point, the Office of Management and Budget itself recognized the error of its ways and specifically exempted the fraud units from the proposed reduction plan.

The importance of controlling fraud, waste, and abuse in the health care industry simply cannot be overstated. The GAO has estimated that fraud and abuse accounts for 10% of this country's $800 billion in total health care costs, and while there may be no way to put a precise figure on it, we are certainly talking about many hundreds of millions of stolen dollars in the Medicaid Program alone.

Indeed, for over a year now, there have been insistent calls throughout Capitol Hill for more, not less, enforcement in the health care system. The GAO has repeatedly stated that only a fraction of health care fraud and abuse is now identified and prosecuted, that the resources currently devoted to fighting health care fraud are too small, and that, without adequate resources, effective investigation is not possible.

Last year, the late Congressman Ted Weiss, as Chairman of this very Subcommittee, wisely called for the creation of a national commission to map out a health care fraud strategy and said, "I do not understand how we can be cutting funds to oversee federal health insurance programs at a time when costs are rising at the speed of light."

Senator Biden introduced the "Health Care Fraud Prosecution Act of 1992" to attack "the multi-billion dollar problem of health care fraud" and underscored the need to make the prevention and prosecution of these abuses a "national priority."

And only a few months ago, Congressmen Stark and Levin introduced legislation to establish a national health care fraud and abuse program.

Indeed, the President himself, in laying out his "Vision of Change for America" in February, talked of the billions of taxpayers' dollars being lost to fraud and abuse and vowed to "root out fraud and outrageous charges" from our health care system.

In closing, I want to emphasize that the Medicaid Fraud Control Units play a national leadership role in detecting and prosecuting fraud and abuse in government-funded health care programs. The Units have been uniquely successful in deterring health care fraud, recapturing program dollars, punishing corrupt and incompetent practitioners, and preventing the physical and financial exploitation of the frail elderly. No other health care fraud enforcement effort has proved as efficient and effective for so long as have the state-based fraud control units. If slowing the growth of health care expenditures due to drug diversion and other Medicaid abuses is to remain, as it must, a serious objective of government, then gutting this remarkable program would be a tragic miscalculation.

Mr. Chairman, I want to thank you for this opportunity to appear before you and would be happy to try to answer any questions you may have.

Mr. TOWNS. Thank you, very much, Mr. Staffa.
Ms. Taylor.

STATEMENT OF BETH TAYLOR, DIRECTOR, TEXAS MEDICAID FRAUD CONTROL UNIT, OFFICE OF THE ATTORNEY GENERAL OF TEXAS

Ms. TAYLOR. Chairman, members of the committee, I, too, am very pleased to be here and to be a part of this.

The term "drug diversion" is often used in a nonexpansive context of pill mills and scrip-selling doctors. The working definition needs to be expanded so that the true nature of the problem can be seen, understood, properly dealt with, and controlled.

Drug diversion is the diverting of any drug paid for by the Medicaid program. For example, drug diversion includes a nurses' aide who throws away a nursing home patient's medication because she decides that she is too busy, got something else to do, takes the medication herself, or sells it. This example may not be big headlines. The dollar amount is usually very small in the individual case. However, the problem is dangerous, inexcusable, pervasive, and should not be tolerated.

In Texas, in the State fiscal year 1992, there were 1,057 nursing homes. That's a lot of drugs being diverted. And, I would say that they're probably happening in just about all of them, on some level.

In Texas, we're fortunate to have some tools to aid us in our fight against drug diversion schemes, and I'm going to go into those in just a minute. But, let me say a case does not have to be big money to be a big object lesson to the Medicaid providers. In fact, I am really coming to the belief, after doing this job for 2 years and 4 months—and before, I was a prosecutor in the district attorney's office in San Antonio—that perhaps the smaller cases are the ones that really offer us the largest object lesson, the biggest deterrent factor.

Let me give you an example of what just happened to one of our cases. We took our case to Federal Court because some DEA drug diversion agents also had a case on this particular doctor. The doctor already had a civil judgment against him out of the Federal Court because he didn't keep records. And so the civil division there said, yes, look, we've got to go after him criminally, you know, push has come to shove. And our case was very small, because we can only look at a small piece of the pie. We cannot look at all of the activity. We don't have the time. We don't have the resources. We cannot even get to all the cases we have. We have to prioritize. We just don't have the people. I have got 38 people to cover 254 counties in Texas. That's it. We don't have a unit, because the money is not there to have a unit the size of New York.

So, we take our case. The U.S. attorney looks at it and says OK. And it was under $3,000 case—it was $2,000 some-odd. But that amount of money is certainly enough to get someone convicted and out of the Medicaid program.

And, in fact, the U.S. attorney called up, the AUSA called up and said, "Would you please prepare an indictment." My folks said, "Fine, no problem, we'd be delighted to," because we do not have prosecutorial authority.

Well, a few days ago, I got back a letter saying, "Gosh, we're declining this because of our threshold. It doesn't meet $10,000."

And I'm going, well, you know, this would have been nice if this had been said in the beginning, since they knew how much money was involved, but then they now come up with this threshold, and $10,000 is a low threshold. Unfortunately, here goes the object lesson, because this particular doctor had made the statement, "Feds aren't interested in me. They want Donald Trump and people like that."

Well, I guess the Federal Government just proved him right. Thank God, Travis County, where Austin the capital is, is going to take the case for us. But there was a missed opportunity. It doesn't have to be some big fancy-schmancy case, like Goldpill. Those are nice and those are wonderful and we all like to have those, but we don't have to live off those, if you really want to make an impact.

Some of the tools we have are: No. 1, in Texas, the law requires that schedule 2 drugs are written on triplicate prescription. Both the pharmacist and the Texas Department of Public Safety must retain copies of the prescription, and this has greatly reduced the amount of fraud we've seen in schedule 2 drugs like Percodan and Dilaudid.

No. 2, in Texas, doctors cannot dispense drugs. There are a few exceptions in some rural areas.

No. 3, Texas Medicaid limits the number of prescriptions a Medicaid recipient can have filled in a month, and the limit is three. In November 1991, regulations were altered to allow unlimited prescriptions for Medicaid recipients under 21 and those residing in nursing homes. And, of course, for the group that is limited to three prescriptions a month, the quantity of drugs can be such that they receive more than 1 month's amount of pills on a prescription. So, you certainly don't want to limit those folks that legitimately need six or seven prescriptions a month.

No. 4, the Texas Department of Human Services, our single State agency, has a vendor drug program which has established a regional pharmacists program. A monthly peer ranking report is generated concerning pharmacies that are Medicaid providers. The report takes the aggregate prescription price, not drug specific, which is divided by the number of prescriptions. If a peer is outside the norm, the regional pharmacist goes to the pharmacy to discover the reason. This report also tracks schedule 3, 4, and 5 drugs.

No. 5, "Point of Sale" has recently come to Texas. Its advantages should be considerable. I think they need to add something to point of sale. Doctors should be required to participate in the same type of program. This would require that just as the pharmacist must, when he dispenses a drug, every time a doctor writes a prescription for a Medicaid recipient, he would contemporaneously enter the information into the computer. This would not be a hardship to the doctor, as it can be implemented just as electronic billing is being implemented.

No. 6, we have an active pharmacy board. They have both compliance officers and investigators. No other board in Texas has compliance officers. There are not many of them, but they are very active, and the board is willing to discipline pharmacists who violate regulations, and we have very few boards like that in Texas.

No. 7, the Medicaid fraud control unit recently acquired the Medicaid abusable drug audit system, MADAS. The system is a computer program that analyzes the most common abusable drugs paid for by the Medicaid program. Then, the system compares doctors/pharmacists with each other and identifies the providers who deviate from the peer norm. This is for the top 10 abusable drugs.

No. 8, Drug Enforcement Administration drug diversion agents, which are as opposed to your regular DEA agents. We have worked with and are presently working with the drug diversion agents. The cooperation has been invaluable. It is good to have a separate unit that deals just with prescription controlled substances. And I know there's a move on to merge them with DEA, but personally speaking, I would hate to see that happen, because once they go with regular DEA agents, you know how they're going to be used—yes, in a very worthwhile manner, but then you will forget the regulation of the pharmacists, the exporters, importers, manufacturers, everyone else that they look at and at least audit three times, or once every 3 years.

While these tools are valuable and we are fortunate to have them, they are not enough. We should not and cannot be satisfied with having only these tools.

Even in the best of economic times, we will always be limited by available resources of money and people. Because of this, we must enable computers and computer programs to do more and more work for us.

All the raw data needed are present in the present computer data bases. Programs must be designed and implemented that bring all the data together in a useful and efficient manner to detect the existence of potential fraud in a timely manner. These programs would be of immense benefit not only to law enforcement but also to regulators of Medicaid programs. A great deal of research and investigative time could be avoided, which means more cases could be investigated.

And I fear, I fear greatly, unless such programs are federally mandated, they will not be implemented by many single State agencies. Their priorities appear to be different from law enforcement priorities. There should not be a difference in priorities with the computer program. Both single State agencies and the Medicaid fraud control units serve the Medicaid program. Both want good providers in the Medicaid program. Both want Medicaid recipients to receive the best possible medical care. Both want Medicaid to be used efficiently.

The computer programs are an area in which we have complete control, if we decide to exercise that control, and it has to come down from the top. We have got to get rid of the mentality, there's got to be a serious paradigm shift—which is probably a better word to use than "mentality" or "attitude"—of having the single State agencies, and this is from HCFA on down, believe that the provider is their customer. How do we best serve the customer? And yes, that's important, but we also have to remember that they are there to regulate the provider and that is an extremely important function.

Computer programs are the only truly viable way to identify potential illegal prescribing practices of the doctors, purchasing hab-

its of Medicaid recipients, and dispensing practices of pharmacists for specific drugs and in a particular geographic area. Arguments that such computer programs compromise patient confidentiality and doctors' prescribing habits are ludicrous, as all the information is already found within the Medicaid system. Without the proper computer programs in place, I know of no way to bring all the already available raw data together to be able to accurately assess the quantity of drugs and Medicaid money being diverted.

And I believe, what I heard you say, Congressman Towns, earlier, I say "Amen" to, when you said that we all need to come together and get it together, because the Federal Government, including Health Care Finance Administration, Department of Justice, all single State agencies, Medicaid fraud control units, local prosecutors and law enforcement must cease indulging themselves in competing interests, get on line, and work together to combat these insidious programs.

This is not the time to cut back on law enforcement officials—investigators nor prosecutors. Drug diversion, drug abuse is an integral part of so many problems in our society, and one of the problems of the rising cost of health care. We cannot be part of the problem. We must strongly, publicly, continuously be part of the solution. We must demonstrate honest, sincere commitment, not just put on a razzle-dazzle show that has no lasting substance.

And what I say here, it applies not only to drug diversion but to all of the fraud, waste, and abuse in the Medicaid program.

And, as President Clinton said to the Boys Nation Class of 1993, on July 24 of this year, "It is not enough to have feelings. It is not enough to have convictions. You must act on them."

The time is past due to put our convictions into action.

Thank you.

[The prepared statement of Ms. Taylor follows:]

TESTIMONY OF

BETH TAYLOR
DIRECTOR, TEXAS MEDICAID FRAUD CONTROL UNIT
OFFICE OF THE ATTORNEY GENERAL

BEFORE

UNITED STATES HOUSE OF REPRESENTATIVES
COMMITTEE ON GOVERNMENT OPERATIONS
SUBCOMMITTEE ON HUMAN RESOURCES
AND INTERGOVERNMENTAL RELATIONS

AUGUST 2, 1993

Chairman, Members of the Committee

As Director of the Texas Medicaid Fraud Control Unit I am very pleased to appear before you today to discuss the ubiquitous problem of drug diversion within the Medicaid program.

The term "drug diversion" is often used in the non expansive context of "pill mills" and "script selling doctors". The working definition needs to be expanded so that the true nature of the problem can be seen, understood, and properly dealt with and controlled. Drug Diversion is the diverting of ANY drug paid for by the Medicaid program. For example, drug diversion includes a nurse aide who throws away a nursing home resident's medication because she decides she is too busy to give the medications to the resident, or takes them herself, or sells them. This example may not be big headlines, the dollar amount is usually small on an individual case; however, the problem is dangerous, inexcusable, pervasive and should not be tolerated. In Texas in state fiscal year 1992, 1,057 nursing homes were Medicaid providers.

In Texas Medicaid is BIG business:

	TEXAS MEDICAID	
	SFY 1991	SFY 1992
Medicaid Expenditures	$4.2 billion	$6.3 billion
Medicaid Recipients	1.7 million	2.0 million
Prescription Drug Expenditures	$246.1 million	$350.0 million
controlled substance drugs	7.6 million	8.9 million
number of controlled substance prescriptions	1.3 million	1.6 million

State Fiscal Year 1993 total prescription drugs expenditures are expected to be $450 million and out of that $15.9 million will be for controlled substances. The number of controlled substances prescriptions are expected to be 1.8 million.

The Medicaid Fraud Control Unit consists of 38 employees.

In Texas the drug diversion problem is most commonly seen in the following schemes:

1. A Medicaid recipient goes to a doctor's office pays cash for a controlled substance prescription and then has the pharmacy fill the prescription . The doctor does not bill the Medicaid program, the pharmacy does.

2. A Medicaid Recipient goes to a doctor for a medical reason and the doctor prescribes a controlled substance. The pharmacy fills the prescription. Both bill Medicaid. The recipient goes back again and again and again reciting the same symptoms, complaining of the same pain.

3. A "middle man" goes to the doctor, he gives the doctor cash for a number of prescriptions for controlled substance with no names or addresses on any of the prescriptions. The "middle man" then "rents" Medicaid cards from recipients and fills out the prescription and goes to the pharmacy to have it filled. The pharmacy bills Medicaid.

4. A Medicaid recipient goes to a doctor for a legitimate medical reason and the doctor gives the recipient a legitimate prescription. The recipient is approached outside the doctor's office with an offer to buy the prescription. The recipient often sells the prescription. A business arrangement is then established.

5. A Medicaid recipient is approached outside the pharmacy after the prescription has been filled and asked what prescription was filled. If the drugs are the "right ones" an offer to buy is made. The drugs are bought and a business relationship is established.

6. A nursing home employee stealing or throwing away a resident's medication.

7. A pharmacist making up prescriptions, adding drugs to prescriptions, increasing the dosage, dispensing one drug while billing for a more expensive one, and increasing the number of dispensing expenses. The scheme of dispensing generic and billing Medicaid for brand name has decreased greatly because now doctors must certify the need for a brand drug rather than a generic drug. There are approximately 50 drugs for which a doctor need not certify.

8. A Pharmacist obtains a legitimate prescription from a Medicaid recipient. Instead of dispensing the drug he gives the Medicaid recipient over the counter drugs and other merchandise. Medicaid is billed for the prescription drugs. And the drugs find their way overseas.

In Texas, we have several tools to aid us in our fight against drug diversion schemes. They are as follows:

1. The law requires that Schedule 2 drugs (i.e. pecodane and dilaudid) must be written on a triplicate prescription. Both the pharmacist and the Texas Department of Public Safety must retain copies of the prescription. This greatly reduces the amount of fraud with reference to Schedule 2 drugs.

2. In Texas doctors cannot dispense drugs. There, of course, are a few exceptions.

3. Texas Medicaid limits the number of prescriptions a Medicaid recipient can have filled in a month. The limit is 3. In November 1991 regulations were altered to allow unlimited prescriptions for Medicaid recipients under 21 and for those residing in nursing homes. Of course, for the group that is limited to 3 prescriptions a month, the quantity of the drugs can be such that they receive more than one month's amount of pills at a time.

4. The Texas Department of Human Services (single state agency) Vendor Drug Program has established a Regional Pharmacists Program. A monthly peer ranking report is generated concerning pharmacies that are Medicaid providers. The report takes the aggregate prescription price (not drug specific) which is divided by the number of prescriptions. If a peer is outside the norm the Regional Pharmacist goes to the pharmacy to discover the reason. The report also tracks Schedule 3 (i.e. hydrocodone brand name vicodin), 4 (i.e. talwin, diazepam, and xanax) and 5 drugs (i.e. Robitussin AC).

5. "Point of sale" has very recently come to Texas. Its advantages should be considerable. Doctors should be required to participate in the same type of program. This would require that (just as a pharmacist must when he dispenses drugs) every time a doctor writes a prescription for a Medicaid recipient he would contemporaneously enter that information into the computer. This would not be a hardship to the doctors as it can be implemented just as electronic billing is implemented.

6. An active Pharmacy Board. They have both compliance officers and investigators. (No other board has compliance officers.) There are not many of them, but they are very active. And the Board is willing to discipline the pharmacists who violate regulations.

7. The Medicaid Fraud Control Unit recently acquired the Medicaid Abusable Drug Audit System (MADAS). The system is a computer program that analyses the most common abusable drugs paid for by the Medicaid program. Then the system compares doctors/pharmacists with each other and identifies the providers who deviate from the peer norm.

8. Drug Enforcement Administration (DEA) Drug Diversion Agents. We have worked and are presently working with Drug Diversion Agents. Their cooperation has been invaluable. It is good that there is a separate Unit within DEA who investigates drug diversions and who has expertise. DEA has also been of great assistance in conducting undercover buys.

While these tools are invaluable and we are fortunate to have them they are not enough. We should not and cannot be satisfied with having only these tools.

Even in the best of economic times we will always be limited by available resources of money and people. Because of this we must enable computers and computer programs to do more and more work for us.

All the raw data needed is present in computer data bases. Programs must be designed and implemented that bring all the data together in a useful and efficient manner to detect the existence of potential fraud in a timely manner. These programs would be of immense benefit not only to law enforcement but also to regulators of Medicaid programs. A great deal of research and investigative time could be avoided which means more cases could be investigated.

The MADAS computer program is an excellent example of the type of program of which we need more. The information that the Medicaid Fraud Control Unit needs for the program has always been available at our single state agency. It was just a matter of having a program that could provide the raw data in a manner that made it useful in a timely and efficient way to law enforcement. Prior to MADAS a Medicaid Fraud Control Unit investigator would have to laboriously plow through reams of computer print outs by hand to determine the prescribing habits of the doctor under investigation.

I fear unless such programs are federally mandated they will not be implemented by many single state agencies. Their priorities appear to be different from law enforcement priorities. There should not be a difference in priorities with the computer programs. Both single state agencies and Medicaid Fraud Control Units serve the Medicaid program. Both want good providers in the Medicaid program. Both want

Medicaid recipients to receive the best possible medical care. Both want Medicaid to be used efficiently. The computer programs are an area in which we have complete control if we decide to exercise that control.

Computer programs are the only truly viable way to identify potentially illegal prescribing practices of doctors, purchasing habits of Medicaid recipients and dispensing practices of pharmacists for specific drugs and in particular geographic areas. Arguments that such computer programs compromise patient confidentiality and doctors prescribing practices are ludicrous, as all the information is already found within the Medicaid system. Without the proper computer programs in place I know of no way to bring all the already available raw data together to be able to accurately assess the quantity of drugs and Medicaid money being diverted.

The federal government, including Health Care Finance Administration, Department of Justice, and all single state agencies, Medicaid Fraud Control Units, local prosecutors and law enforcement must cease indulging themselves in competing interests and get on line and work together to combat these insidious problems.

This is not the time to cut back on law enforcement officials (investigators nor prosecutors). Drug diversion, drug abuse is an integral part of so many problems in our society. One of the problems is the rising cost of health care. We cannot be part of the problem. We must strongly, publicly, continuously be part of the solution. We must demonstrate honest, sincere commitment, not just put on a razzle dazzle show that has no lasting substance.

As President Clinton said to the Boys Nation Class of 1993 on July 24, 1993 "It is not enough to have feelings, it is not enough to have convictions, you must act on them."

The time is past due to act upon our convictions.

Mr. Chairman, I want to thank you again for this opportunity to appear before you. I will be happy to try to answer any questions you may have.

Mr. TOWNS. Thank you. Thank both of you for your testimony.

Let me begin, I guess, with you Ms. Taylor. You stated that nursing homes are a common area of drug diversion in Texas. Can you describe, for this committee, some of the cases your office has been involved in?

Ms. TAYLOR. They're very, very small cases, but you have a nurse med aide—medication aide. This person is paid minimum wage, at best. There's usually nothing more than minimum wage, and they're understaffed, and they have rounds to make with their little cups, giving each patient medicine. Something may come up and they legitimately may find themselves too busy.

However, then more help should come in. They should, you know, bring someone in to say, "Hey, look, I can't do this. Somebody needs to give them their medication."

We have had cases there, where if they had only given the person their high blood pressure medicine, they wouldn't have had that stroke, wouldn't be paralyzed now, wouldn't be dead now. That's how dangerous and important that sort of thing is.

They're very, very small cases. It may only be, what you catch may only be 1 days' or 2 days' or 3 days' worth of medication, because if you know it's happening and you can look at the chart and see that they've charted this medication and then you can have the person tested. The recipient tested, to see if that medication is in his or her bloodstream, and that's the way we've done some of the cases. And they're small cases.

A lot of prosecutors don't want to waste their time with it, and on their behalf, having been a prosecutor, where you have all of the cases are investigated and you have a huge, huge case load; and then you have somebody like us coming in or the securities board coming in and wanting their cases done. It's something new you have to learn. It's time consuming, but it's worthwhile and if we have the attitude coming down from the top, "Hey, these are important," then people get on board, because for lack of a better phrase, they realize the political correctness of it. And, if that's what we have to use, that's fine with me.

Mr. TOWNS. Thank you.

Mr. Staffa, have we done anything in that area, here in New York? Have we looked at cases like that?

Mr. STAFFA. Yes. It doesn't fit the definition, the most usually understood definition of what the drug diversion problem is. I mean most of that is the big bucks being lost the way we talked about it before.

We also monitor all the nursing homes in the State, as does the State Department of Health. This lack of dispensing medications to patients is a fairly frequent type of situation, and my particular office treats those—we have a patient abuse statute in New York, which makes it a misdemeanor to involve oneself in not dispensing the medication.

And also, hand-in-hand with that, is that the nurses will generally change the charts to make it appear as if the medications were given, but yes, we do have those cases. We do those on a regular basis, and we treat those as patient abuse cases.

Mr. TOWNS. Ms. Taylor, again, does the large illegal alien population in Texas present unique problems, in terms of investigating drug diversion cases?

Ms. TAYLOR. It can present a problem investigating any kind of case. If there are Medicaid recipients involved, that you have to interview to find out if the doctor or whoever has been doing his or her job, because they're harder to locate. And, if you can locate them, needless to say they are very reluctant, because of their status. They worry about Immigration.

So, sure, it presents a problem in our cases. It presented a problem when I was a prosecutor, just in the general nature of things. They don't want to come forward.

Mr. STAFFA. If I might, it goes right to the heart of the problem in New York City, with the drug diversion.

Mr. TOWNS. I was coming to you, next. Go ahead.

Mr. STAFFA. We talked about the pharmacists and the loss of license and what remedial effect that might all have.

But, at the very heart of this "playing doctor" scam in New York are a lot of illegal immigrants who are the entrepreneurs, who own the clinics, and who own the pharmacies, and who are not licensed. The licensed people are just employees of the people who are really making the big bucks.

And, at the first sign of trouble, the first sign of a State or prosecutor audit, they're out of here. They're not concerned about preserving their license. They're concerned about taking the millions that they have stolen and go back home to Pakistan.

So, that's where the illegal immigrant problem has had a major impact on us, because many of the main players have no roots here, and they're here primarily to steal from the system and then they're gone, and their license is not something that they're concerned about.

Mr. TOWNS. Let me ask you, Ms. Taylor, in terms of the license, is it mandatory, if they are convicted in Texas, that they lose their license? Be it a pharmacist or a doctor?

Ms. TAYLOR. I can't really tell you what all the medical boards, what their rules are. I know that there are certainly people who have been convicted that are either suspended for a short period of time.

Unfortunately, I find that most of the boards, you protect your own. That's the business they're in. And, it doesn't seem—we had a case which, and prosecution was declined on this case by a local DA. And you've got to remember, also, the people we go after, the "big people" in the community, they usually aren't the folks that don't have money. And so, local DA's races, contributions are made, pressure is put on, and don't misunderstand me. We certainly have a number of DAs throughout Texas that are absolutely marvelous and will prosecute what we bring to them, if they believe we can prove it beyond a reasonable doubt.

But, those types of influence are always present. It's always hard to believe that gosh, that doctor that everybody likes and my kid goes to and, you know, my neighbor's kid goes to, how could they possibly be doing something wrong. And, when you get down to the boards, except for the pharmacy board and our nurses' board, they are very, very reluctant to do anything about their members, even

put them on probation. Or, if they do put them on probation, they leave them in the same situation in which they were before.

Mr. TOWNS. Before I yield to the ranking member, Mr. Staffa let me raise this with you: I notice in your testimony that you highlighted the fact that low-level employees, in terms of the fact that clerks would sort of instruct patients in terms of what to do or what to say, which further distanced the physician or the person that's actually in charge of the clinic, you know, from the case. What can we do that might be helpful to be able to assist you in terms of developing a case, because I understand that if you have the clerk saying "do this," and then the doctor saying, "well, I didn't know anything about it. The patient actually told me this, so therefore, based on my medical training, that I'm responding to what the patient said to me, what do you want from me?"

What can we do to be helpful?

Mr. STAFFA. Well, sometimes we help ourselves in that area. We send undercover operatives in, and we basically are there during the examination, so that superficial language that goes on outside still has no connection to medical treatment or lack of medical treatment that's going on inside, when you go to see the doctor.

In many situations, the doc, even though the clerk is priming you as to what to say, the doctor will say nothing more than "What kind of drugs do you want today?"

So, that is not the biggest problem in those clinics.

The biggest problem is making the case against the clinic owner. The clinic owner is the guy who's making the big bucks there. A lot of these doctors who work in these clinics are just getting a salary or a percentage of whatever prescriptions they're distributing. But I don't know if you can legislate or assist us in legislating against that type of activity.

The biggest problem, and it's for us, it's to make as many cases as we can and cause a deterrent effect. And, the other thing to do is to have some of these front-end controls in place. And, that's not a panacea, either. The front-end controls, if they were working perfectly, would weed out the bad apples before they get into the program.

But, a lot of times the bad apples are just of the last bad apple that you kicked out, and you can't kick them out for being a cousin. You basically have to evaluate them separately. That's a problem.

But, in this country, you are not excluded from entering any of these entitlement programs just because a relative of yours has been charged with Medicaid fraud, unfortunately.

Ms. TAYLOR. And, if I can add to what he said, as soon as you start legislating and it gets to be too specific, then you cut out so much that we might be able to do. Because, at least in Texas, if there's a specific law, you can't use the general law. And, as soon as you get something specific, you know they will find some way to wiggle around that.

So, I would just like to see, mostly, a paradigm shift in the way we think about things.

Mr. TOWNS. Thank you, very much, and my time is long expired. Let me yield to the ranking member, Mr. Schiff.

Mr. SCHIFF. Thank you, Mr. Chairman.

I want to take up, both of you talk about terms of prosecuting more cases, spreading the deterrent effect. Ms. Taylor, did I understand that your particular unit in Texas does not, in itself, have prosecutorial authority?

Ms. TAYLOR. No, we don't have prosecutorial authority.

Mr. SCHIFF. So, you must present the case to a prosecuting agency?

Ms. TAYLOR. Yes. We depend upon the kindness of strangers, literally. We have excellent working relationships with some DAs, and with some AUSAs. But, we do, we have to go and sell our case and hope they have room for us.

Mr. SCHIFF. Mr. Staffa, what about your particular unit?

Mr. STAFFA. No, we prosecute the cases. We take the cases from beginning all the way up through appeal.

Mr. SCHIFF. So, there's not necessarily uniformity as to whether these units can or cannot prosecute——

Mr. STAFFA. That's correct.

Mr. SCHIFF [continuing]. So it's a different situation for different States.

Mr. STAFFA. That's correct.

Mr. SCHIFF. In terms of cases that are being handled now, and I'm well aware of the difficulty in putting together these and any other white collar crime cases, but can you give me an idea, in the last year or so, how many cases, in your case, you've presented for prosecution, Ms. Taylor? In your case, Mr. Staffa, how many do you actually have prosecuted? In which you've gotten—well, let's say you've presented it. You've asked the prosecutor, won't you take this case.

How many are we talking about in the last 12 months?

Ms. TAYLOR. I think I have that in my notebooks. I'm not a statistics person, so I don't remember these numbers.

Mr. SCHIFF. OK, otherwise I'll take a round number, which ever you prefer.

Mr. Staffa.

Mr. STAFFA. I don't have the exact statistics, but it's close to 100. We, at any given time, we may have hundreds of investigations ongoing, hundreds.

Mr. SCHIFF. You're statewide——

Mr. STAFFA. Yes, yes. We have seven regional offices throughout New York State. The, about 65 percent of total Medicaid billings in the State is in New York City, and our resources in the office are divided about along those lines. So, we have about 65 to 70 percent of our staff down here, and the rest is spread out throughout the State.

Mr. SCHIFF. You estimate about 100 cases in the last year?

Mr. STAFFA. Yes. It varies, but it's enormous. The case load is enormous.

The point that might be helpful is that the case load generally has been increasing and the size of the frauds that we're seeing has been increasing. So that the differences that we see in the types of cases that we bring usually has to deal with a heavy focus on a particular area, both by us and the oversight agency being the State Department of Social Services in New York.

Once we see a particular abused area, we marshal our resources and go after it. Of course, this is sometimes after the cat has gotten out of the bag. But then, we'll see the shift in some kind of other methodology to steal from the program.

So, this "playing doctor" scam and this drug diversion scam is something that's currently very hot. We had tremendous losses in the area of laboratory billings, 3 years ago, and they were basically these phony blood tests that were being given. And every patient who went to a city clinic had to submit to a blood test, and they were bartering these blood tests as if they were currency. So, that was the big scam 2 years ago.

There was a major orthopedic shoe scam, 2 years before that, so we try to be as vigilant as we can, but these scams shift from scam to scam to scam, because we're dealing—not are we necessarily dealing with—and we do, in some instances—with a dentist who's giving you a cleaning and charging you for a deep root planing and scaling. He's basically giving you some service, but then adding some services. We're not dealing with that when we talk about some of the schemes that are indigenous to the city of New York.

We're talking about people who are in the program for no reason but to steal from the program. And those are the people who shift from scam after scam after scam. As soon as heat is felt in one particular area, it moves to another.

Mr. SCHIFF. Ms. Taylor, did you come up with anything?

Ms. TAYLOR. Yes. In fiscal year, in Federal fiscal year 1992, we referred for prosecution 76 cases, and what I try to do is have a blend of simple and complex cases, in an effort to keep providers on their toes. Whether it's a simple case of a nurse aide slapping a resident to having neglect cases that are so bad that you could put both of your fists in the decubitus ulcer, from simple fraud cases, to complex fraud cases that are several hundred thousand dollars worth.

And, an area that we've had a lot of problems in are ambulances, transporting walking, mobile people to dialysis clinics.

Mr. SCHIFF. Let me follow up on that. By the way, I agree with the implication that I think you just made, Ms. Taylor. I think the greatest value of these units is the deterrence effect. You know, you can't count how many tigers didn't get into your city, but because this is there, you have to assume a certain number exist.

With that in mind, I am curious, though, about financial remuneration you could directly say "we got because of this." How much, in the way of restitution, say in the last 12 months—a round number would be fine—have your units obtained?

Ms. TAYLOR. Restitution is something that I do not determine, that my unit does not determine. That is from the——

Mr. SCHIFF. From the judge, the prosecuting agency?

Ms. TAYLOR. Right. Restitution figures I don't have with me. We, we do identify overpayments. Identified, that sort of thing, which in 1992 was over $1 million, but you have to remember——

Mr. SCHIFF. What? I'm sorry, what was that you just said?

Ms. TAYLOR. It was over $1 million in——

Mr. SCHIFF. What was?

Ms. TAYLOR. Overpayments identified.

But, you have to remember that when we look at a case, at least in Texas, we only look at a very narrow slice of the pie. One doctor, one provider, we look at from "x" to "y" period of time. We don't go beyond or above, because we don't have the resources to do it. Then a lot of other people wouldn't be looked into.

What I would hope would happen, and what does not happen in Texas is that, at that point, after we've looked at the slice of the pie and determined, in our opinion, beyond a reasonable doubt, that fraud exists, I would hope the single State agencies would then go in, who are responsible for gaining the recoupment, getting the money back. That's not our responsibility. That is strictly for the single State agencies. That then they would go in and conduct a complete fraud audit of the providers.

And, quite frankly, in Texas that doesn't happen. Several years ago, before I ever got to the unit, our single State agency had their auditors just slashed. The legislature didn't want to fund it.

You can surmise——

Mr. SCHIFF. Single State meaning the agency that manages the Medicaid program in Texas——

Ms. TAYLOR. Right.

Mr. SCHIFF [continuing]. Is what you're talking about?

Ms. TAYLOR. Right.

Mr. SCHIFF. And it would be your view that they would be responsible primarily for doing broader audits, once someone's been identified as misusing the system——

Ms. TAYLOR. Right.

Mr. SCHIFF [continuing]. For the purpose of full-scale recovery?

Ms. TAYLOR. It's part of their responsibility to collect the recoupment money, the overpayments identified, and I would hope that they would have an auditor then go in and do this.

Like I said, unfortunately, a number of years ago, the State legislature slashed that part.

Mr. SCHIFF. Mr. Staffa, again, do you have figures in round numbers——

Mr. STAFFA. I will provide you our yearly figures. I don't have those with me, now, but I can tell you that just for physicians and pharmacists, since our unit was put into place, there have been 728 defendants and $30 million in fines and restitution, and hundreds of millions in Medicaid savings.

And, we actually can quantify, in some instances, the deterrent effect. I alluded before to an orthopedic shoe scam that happened in New York about 3 years ago. The prescam billings for orthopedic shoes in New York, and orders for orthopedic devices, were somewhere in the nature of $17 million for many, many, years. During this scam, the billings had gotten up to over $100 million, and the increase happened within a 2-year period. After there was an intense level of prosecution by my office, and we had prosecuted over 30 doctors and durable medical equipment companies, and after the State started doing, the State unit had done a lot of audits in the area, the billing dropped back down to $17 million, which is probably the somewhat legitimate level. But, everything above that, up to the $100 million, was fraud.

So, in that instance, by looking at how the billings went up and went down, over a course of just a short period of years, we were able to show the deterrent effect in that area.

Mr. SCHIFF. Let me just conclude by saying, obviously, I hope the point I was getting at is, legislators, whether it's us or State legislators, look for dollars, especially when dollars are very short. The best argument you can make is dollar-for-dollar, plus savings in deterrence and actual recovery.

Mr. STAFFA. Let me tell you the problem, if I could just interrupt for one moment, for the prosecutor's office is that we're prosecutors. And, our primary objective is not to go out and collect the money. And that causes a number of problems.

When there are budgetary problems, federally and at the State level, the emphasis starts to shift in a way that sometimes hurts our abilities as these single State units, to prosecute these cases, for this reason: The State agency, which is also not only responsible for oversight of the program, and to do these audits, they're also responsible for identifying fraud in the first instance, and then making the referral to us.

In tough budget times, the emphasis shifts to collecting money and when they start doing audits for the sole purpose of collecting dollars rather than identifying fraud, we get no referrals. So, every time, in lean years, and it's been lean for the last 5 years, in those years, our referrals from the State agency go down to practically zero, because the emphasis is on collecting the money.

I guess what I'm trying to say is hopefully we could strike a better balance, but the balance always shifts in lean times.

Mr. SCHIFF. I thank both witnesses and yield back to the chairman.

Mr. TOWNS. Thank you, very much, Congressman Schiff.

At this time, I yield to Congressman Mica.

Mr. MICA. Thank you, Mr. Chairman.

I'm not sure if I noticed a conflict in testimony or recommendations to this panel, but Mr. Staffa had recommended specific crime legislation. In fact, I think he mentioned repurchase, something dealing with repurchasing. And, Ms. Taylor had said don't get specific, that it was better to deal generally.

Could you both—I was anxious to go back and maybe look at some type of Federal legislation that we could go after these folks specifically. I mean, we had the prosecutors before this saying that they were sort of picking and choosing among the various statutes, but sometimes didn't have specific legislation that they could go after these folks with.

Could you both address that?

Ms. TAYLOR. Let me start, since I'm the one that was concerned about very specific legislation.

What I want to make clear, and I don't think there is a conflict of interest between Tom and myself. Tom was giving a specific example of the low-level clerk or receptionist saying "give these symptoms, that's what's in today," and then Congressman Towns said and Tom said, well, you know, you need to get after the doctor and that sort of thing. And Congressman Towns asked is there any specific legislation.

What I was talking about was in a specific instance like that, we have to be very careful not to get to something very, very specific.

Mr. MICA. But you support, say, repurchase——

Ms. TAYLOR. Absolutely, 100 percent.

Mr. MICA. Looking at that, especially.

The other thing that concerned me is, you know, if I go down with Congressman Towns and we go up to 42nd Street and I'm driving the car, and I own the car, and Towns and I decide we're going to hold up this pharmacy and he's got a gun and he goes in and holds it up, and we conspired together to do it, we're both going to jail, eventually.

But, you know, you've got one of these cards or you can write prescriptions, you go in and do this, the likelihood of getting caught is not very great.

You also said that we can't go after folks, Mr. Staffa, that are financing these operations. That, you know, that there's a doctor, the pharmacist, and then you said that there's also a number of folks, you know. I think you referred to Pakistanis or whoever, just for general reference, that we can't go after. But, why can't we tailor the law that says if you participate in this, that you go, too.

Mr. STAFFA. Well, we can go after them. I'm just describing the difficulty in getting to that person. For me to make the case—let's talk about the typical drug diversion case.

He goes to the clinic owned by the Pakistani person. The recipient goes in there. The recipient gets a prescription. That's all he wants. He may pay for it, but he gets a prescription. He walks out of the place. That clinic may bill for fraudulent services, having been billed as if it were medical treatment. That clinic may also be getting kickbacks from the blood lab, which they're referring the blood test to, or from the pharmacy where they're telling the recipient to go to.

We can get to the owner, but to get to the owner, we have to get the cooperation of the clerical people in the office, the office manager, and the doctor. If we can show that direction is being given from the boss, just like in mounting any criminal case, you can make the case.

Mr. MICA. Is there adequate Federal statutory language to deal with that?

Mr. STAFFA. Well, yes, there is. But we were talking about the statute that is missing, that we need, in the drug diversion case. We need to be able to get the recipient who walks out of that place, and the non man who's out on the street, collecting the money. Those people are not billing the Medicaid system.

I'm a Medicaid prosecutor. My jurisdiction is that narrow. I can only prosecute for Medicaid fraud. I can't make a Medicaid case against a person in the street buying those drugs.

So, if we can make a statute—both Federal and State statute—which describes that drug diversion practice that we're seeing, and make it a felony, it will be a lot easier for me to elicit cooperation from all those people, up and down the ladder in these scams.

Ms. TAYLOR. And, when you're making that statute, if you'd please address doctors who are not Medicaid providers who sell the scrips, and then the scrips are taken to the pharmacy and Medicaid gets billed for the drugs.

Mr. MICA. Another question: You described, Ms. Taylor, a situation where you took a small amount case, 2,300 or something, that you wanted prosecuted at the Federal level.

Is that a local decision, within the State? We're dealing with an agency of the Department of Justice here. To your knowledge, and Mr. Staffa, do you have the same problem in New York? Are the Feds not going after the small time cases?

Ms. TAYLOR. In our situation, each district has their own threshold. Some offices within the district don't, others do. And I would be the first one to admit a lot depends upon their case load.

I think they, along with others, need a paradigm shift and to see the importance of the object lesson, even when the case is "small."

Mr. SCHIFF. Mr. Staffa, do you have——

Mr. STAFFA. Well, in New York, we deal with all the U.S. attorneys throughout the State, so we have about five offices, but the answer is yes. If it's small, they're not going to take it. And they're not going to take it because they're busy, and it falls way down on their order of priorities.

But, it's not that big a problem for my office, because we can do it. We can prosecute the case. We're a prosecutor's office, so we can do it.

Mr. MICA. One last question, if I may, Mr. Chairman.

The other part about all of this is financing, and you seem to indicate, Ms. Taylor, that most of your problem was that the State legislature wouldn't provide the funds.

Was that a correct assumption?

Ms. TAYLOR. Texas——

Mr. MICA. You said several years ago they cut the funds, the legislature—you're paying 25 percent of the, of 100 percent operation. What's the total of your budget, and what's the State match, at this point?

Ms. TAYLOR. Our budget is over $2 million, I believe, and we get 75, 25.

What I was talking about, when the State legislature cut funds, that was for our single State agency, of which we are not a part. That's the Department of Human Services. That was part of their budget.

You know, Texas is just like every other State, probably, around here, that they don't have the resources. They have all sorts of priorities. I would just hope that ours would become one of those top priorities.

Mr. MICA. Did you—I don't recall. I know you talked about the amount you reclaimed. Did you mention to Mr. Schiff or in your testimony how much money your office had recouped?

Ms. TAYLOR. We do not——

Mr. MICA. Because you're working with a $2 million budget and 75 percent of it is federally funded. Do you have any idea of what you all have——

Ms. TAYLOR. We do not recoup. That is not our function. That's the Department of Human Services. The single State agency does the recoupment.

Mr. MICA. Do you have any idea what they've gotten back?

Ms. TAYLOR. Not much. That is, quite frankly, not a top priority with them.

Mr. STAFFA. Congressman Mica, we have lost significant funding over the years, which has meant that we did not get the Federal share from the previous years.

While the program in New York, the Medicaid program, went from $3 billion up to what it is now, $18 billion, which is 20 percent of the entire amount spent in the country, so when it went from $3 to $18 our office resources have gone down 33 percent.

Mr. MICA. What's your total budget, may I ask?

Mr. STAFFA. A little over $20 million.

Ms. TAYLOR. We have $6 billion for Medicaid in the State of Texas in 1992. My level of funding has stayed the same. We never match, never reach the level of funding that we could have from the Feds. There's always money left over. The State legislature doesn't appropriate it, and, quite frankly, I don't know if it's there. And if our funding were ever lowered, our numbers would drastically go down, and whether we'd even be funded.

Mr. MICA. Thank you, Mr. Chairman, and also thank you for—this is one of, I think this is the most significant and most revealing committee hearing that I've participated in. It's absolutely astounding. We've learned a lot, and I hope we can work on some remedial legislation in a bipartisan fashion. I know the ranking member has already expressed that, and I join in.

Mr. TOWNS. Thank you very much, Congressman Mica. I agree with you that this has been very informative.

Let me again, by thanking you, the members, for coming, and I also would like to thank you, Ms. Taylor and Mr. Staffa, for your very important testimony. I would like to thank all the other witnesses for appearing here today. We have heard several important recommendations that I intend to discuss with the Secretary of Human Services, Donna Shalala, in terms of some of the recommendations and suggestions that were made here today.

I come away more convinced than ever that Medicaid fraud is widespread, and that we need a concerted effort, at all levels of government, to stem this illegal activity.

So, let me thank all of you, again, for coming.

This subcommittee is now adjourned.

[Whereupon, at 12:20 p.m., the subcommittee adjourned, to reconvene subject to the call of the Chair.]

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